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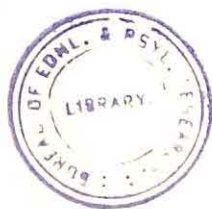
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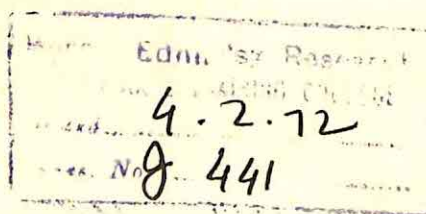


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Symposium on psychoanalysis and validation*

I. Experimentalists and Therapists: The Dynamics of a Conflict Situation

By T. R. MILES

My main task in this paper is to make explicit that a conflict situation exists. By this I mean that there is a large-scale failure of communication between therapists on the one hand, including analysts in particular, and experimental psychologists on the other. Now for psychologists of all people, it seems to me, this state of affairs is a sheer disgrace. Failure of communication is itself one of the things which psychologists study. Only last year at the British Psychological Society conference we had an extremely interesting paper from Mr Hotopf in connexion with newspaper correspondence and the occurrence of misunderstandings (Hotopf, 1959); and both experimentalists and analysts alike are concerned, each in his own way, with the problem of communication. Yet when it comes to communicating between ourselves, we have signally failed to put our own house in order.

Now the matter is not purely a cognitive one. When issues such as that raised under the general heading 'Psychoanalysis and Validation' are discussed, my experience is that people's emotions become aroused. I do not mean that discussion is necessarily affected by personal animosities as such; but when one is thoroughly convinced that 'their side' (which ever 'their side' may be) is saying something stupid, there are almost certain to be undercurrents of hostility which make it difficult to consider issues on their merits.

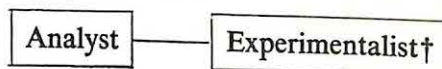
My title refers to the 'dynamics' of a conflict situation. In other words I want to raise the issue of what forces and tensions are likely to be operative when analysts and experimental-

ists try to communicate with each other. By way of a parallel, I should like to cite the work of Dr Elliott Jaques (1951) in the industrial field. Dr Jaques found that in the particular firm where he and his team were working, these undercurrents of hostility were continually bedevilling negotiations, and that, unless there was some degree of 'working through', satisfactory agreement on methods of payment and similar issues was very hard to achieve.

What I am suggesting, then, is that in our present situation the undercurrents of hostility which experimentalists feel towards analysts and vice versa need to be brought into the open and clearly recognized. In a course of informal talks given by Dr Jaques, at which I was present, the group was invited to consider the dynamics of the situation where A is the employer of B, this situation being expressed diagrammatically as follows



Tonight I want us to consider the dynamics of the experimentalist-analyst situation, which we may symbolize as



In particular I want us to examine the forces in this situation as a result of which communication has become so much hampered.

† By convention the name appearing higher on the page is taken to indicate superiority in some sense; for present purposes I am assuming that neither side is 'superior' to the other (compare the use of a 'round table' for certain varieties of committee meeting).

* This symposium was held at the Annual Conference of the British Psychological Society in Hull, April 1960.

The dynamic approach is, of course, that used by practising analysts; and psychoanalysis is in effect the study of the dynamics of a special kind of two-person relationship, where those concerned are at close quarters over a long period of time and enter into a special relationship (of a non-symmetrical kind) with each other. What we have tonight is a large multi-person situation; and what I had in mind in convening this symposium was a sort of mass group therapy during which experimentalists can voice their complaints about psychoanalysis in general and analysts can answer in kind; this seems to me a necessary preliminary if difficulties over the validation of psychoanalytic concepts can be constructively examined. What I want in this introductory talk is to bring both sides together with a view to working through hostilities and misunderstandings.

Now to start off I shall try to present each side in caricature as seen by the other. I shall in effect be making explicit the commonly accepted stereotype of the dyed-in-the-wool analyst and that of the hard-boiled experimentalist. These caricatures are unkind, and are intended to be. I would emphasize, however, that they *are* caricatures, as opposed to accurate pictures. They are not attacks on anybody, but are intended simply to show in an exaggerated form the way in which either side views the other.

First, the caricature of the experimentalist. The experimentalist is verification-mad and statistics-mad. So long as he has tables of statistics he is perfectly happy, but he fails to appreciate that unless his statistics measure something worth measuring his research is not worth the paper it is written on. Moreover, he assumes without question that psychologists should make the 'respectable' sciences of physics and chemistry their model for imitation without appreciating that useful knowledge can be obtained in all sorts of different ways. And what does he produce at the end of it? He spends hours, it would be said, making people complete questionnaires telling him whether they feel lonely at nights, etc.; he correlates

extraversion-introversion with neuroticism and carries out elaborate factor analyses, and finally produces a scientifically impeccable table of statistics. But the whole procedure is helpful only if we assume that what people say in reply to questions like 'Do you feel lonely at nights?' is scientifically valuable, if we assume that the personality of the interviewer makes no difference to the situation, and if we assume that the subject's answer is undistorted by unconscious or semi-conscious hopes and fears. The whole research, one feels, is pretty futile; and if in addition adherents of this approach see fit to deliver emotionally charged attacks on psychoanalytic theory without appreciating their own emotional bias, then one cannot but feel that profitable communication with such people is an impossibility. How much better if they would spend just a few hours watching a child with a sand-tray! Such observation may not supply immaculate tables of statistics, but how much more insight it would give them into human motivation, and how difficult it is to communicate with people who lack that insight!

Now for the caricature of the analyst. At case conferences where analysts were present I have heard diagnoses, put forward in all seriousness, which sound exactly like caricatures of psychoanalysis such as one might read in *Punch*. And if one raises the question of validation there is surprising lack of interest. Here are some of my own experiences, exaggerated and distorted in the interests of caricature, but not, I think, so exaggerated as to be merely grotesque. At one stage during my training when I raised the question of statistical validation I was told that the purpose of the clinic team was to cure people, not to provide statistics; and I received the impression that the speaker was *frightened* of statistics, fearing, I thought, that they must be his enemy and not his friend. On another occasion I made explicit an assumption which I had taken for granted, viz. that in the sessions where we observed the behaviour of young children and their mothers, this was designed to test the truth of Klein's hypothesis that early interaction between mother and child was of crucial importance for

later development; and I was at once told not to go to the baby-watching sessions with the intention of testing hypotheses—that was quite the wrong sort of approach. And on a third occasion my demand for validation was 'interpreted' back to me as a sign of my own aggression against those in charge of the training course—and no doubt by this time I was feeling very aggressive indeed! The analyst, in caricature, is one who comes out with some bizarre interpretation, e.g. that 'The mint with the hole in it' is a successful advertisement because the hole is a symbol of the vagina or uterus, and, when one protests, says 'Ah! but you've got very strong resistances to believing this', which is, of course, quite unanswerable! Finally, I have heard analysed people compared to the more unhealthy type of religious sect, in which one has to sink one's personality in a sort of religious fanaticism, where criticism is not tolerated, and where the uninitiated are regarded as pretty well beyond the pale. A 'fundamentalist' Freudian is on this view not dissimilar to a fundamentalist Christian, and about as much of a menace!

So much for the caricatures. There is another question about the conflict situation which I should like to raise, namely, What are the conditions in which tempers begin to become frayed? The answer, I suggest, is that they begin to become frayed as soon as the discussion becomes *ideological*. I am using the word 'ideological' deliberately, and I will try to explain what I mean by it. We need to draw a distinction, I suggest, between *intra-contextual* statements, i.e. statements within the context of some particular approach to psychology (such as the psychodynamic approach or the neurological approach) and statements *commending* a particular approach. These different approaches to psychology may be labelled 'ideologies' on account of the analogies between them and ideologies in the strict sense, i.e. political ideologies such as communism and fascism; For illustration purposes let us suppose that a child therapist is discussing a particular case with a colleague, and says as follows: 'From the way in which he

slapped the toy policeman I don't think he has really come to terms with his aggressive feelings; but the resentment is very much below the surface and I didn't think it was a good time to interpret'; and let us suppose that, on the basis of independent considerations, the colleague replies, 'I think the resentment is fairly near the surface; perhaps you should have interpreted'. Now the statement 'The resentment is near the surface' and its contradictory, 'The resentment is not near the surface' are examples of intra-contextual statements; they are statements made within the context of the psychodynamic approach. We need to note that, although there can be disagreement as to which of the two statements is in fact true, there are fairly well agreed criteria for settling the matter; both participants are, as it were, playing an agreed game according to agreed rules. Let us now consider the following statement coming from, say, a neurologist or from someone else with a different ideological approach: 'I discussed the case with two child therapists, and they became wildly excited because the child slapped a toy policeman'. We can recognize at once the difference in tone and the feelings of tension to which such a statement would give rise. The statement, in our present terminology, is an ideological one; its function is to disparage the psychodynamic viewpoint or ideology. It is when the discussion starts to be ideological that tempers begin to become frayed.

Let me quote another example. At a recent case conference at a Child Guidance Clinic a child was reported as writing mirror-wise and reading words backwards, e.g. *was* for *saw*, *tac* for *cat*, etc. Those present at the conference immediately started to discuss what particular unconscious phantasies were operative so as to produce this behaviour. One person, however, began to commend neurophysiological language, and suggested that it was an aphasic type of disability—the label 'aphasic' being understood to indicate some failure of cortical development. This suggestion seemed to make some people very cross, and led to a much more heated and impassioned debate than was

normally customary. In other words, the discussion had become ideological; we were no longer discussing the question 'What are this child's unconscious phantasies?', but a challenge had been made which amounted in effect to saying, 'You ought not in this case to be talking about unconscious phantasies at all'. In the same way, had the case come up at a clinic with a different orientation, two psychologists with a neurological orientation might have disagreed amicably as to which part of the brain was affected, but if someone with a psychodynamic orientation had been present and had said, 'You are wasting your time arguing in this way; you ought to be considering unconscious phantasies', the atmosphere would again have become emotionally charged. Indeed any ideological statement carries, at least implicitly, the suggestion that other ideologies are inferior, and that those who practise them are wasting their life's work; hence it is hardly surprising that strong emotions are aroused.

There is another reason for exasperation, a reason connected with the issue of falsifiability. Evidence can make an ideology plausible or implausible but can never finally dispose of it, since it is always possible to buttress one's ideology with *ad hoc* assumptions. To cite the well-known textbook example, if a Ptolemaic astronomer finds that an observation does not square with his system he postulates an epicycle or set of epicycles. There is, we are told, no crucial experiment that will refute the Ptolemaic system; what has happened in this case and in many others, is that the system has gradually been abandoned. Now the bringing in of *ad hoc* hypotheses is commonly regarded as disreputable; and if one is opposed to a particular ideology it is very easy to accuse its advocates of this disreputable move. In the case of the psychodynamic ideology, for instance, it might transpire that a particular action had been done from a perfectly sensible and realistic motive, and it would thus seem that an explanation in terms of unconscious motives was mistaken. In this case one saves the unconscious motive hypothesis by saying

that the behaviour was 'overdetermined', by saying, in other words, that both sets of motives were operative. I am not of course saying that this is in fact a disreputable move by analysts—merely that to the tough-minded experimentalist it must necessarily seem so, and all the more so if the analyst happens to be untrained in the logic of scientific method and is quite unaware that problems connected with falsifiability even exist. From the analyst's point of view, however, the matter is different. He can argue, perfectly correctly, that a great scientist is not necessarily one who gives up when a piece of evidence appears to go against him. He may be someone who persevered, like Freud, *in spite of* apparently adverse evidence. Those who are convinced that the psychodynamic ideology really is 'getting somewhere' will accommodate adverse evidence as best they can, and from their own point of view of course they are right. Inevitably, however, such procedure seems disreputable and exasperatingly high-handed to their opponents.

Moreover, the text-book notion of the 'crucial experiment' is more problematic than appears at first glance. To return to our earlier example—Does a child write mirror-wise because of an aphasic disability or because of the operation of unconscious phantasies? You might think that systematic experimentation would settle the matter once and for all. But would it, even in theory? If there is an aphasic disability the correct policy, presumably, is remedial coaching; if it is a matter of unconscious phantasies the correct policy is psychotherapy. There are thus four possibilities: (i) therapy and improvement, (ii) therapy and no improvement, (iii) remedial coaching and improvement, (iv) remedial coaching and no improvement. Now opponents of the psychodynamic ideology would feel happiest if the result was (ii) or (iii), but they would scarcely be worried by (i) or (iv), since in the case of (i) it would not follow that the improvement was *due to* the therapy, and one could always argue in the event of (iv) that the remedial coaching was not efficiently carried

out. Similarly, a therapist would feel vindicated if the result was (i) or (iv), but if the result was (ii) he could perfectly well argue that the therapy did not go far enough, and in the event of (iii) he could say that the personal relationship, i.e. the transference, in the remedial teaching situation was in effect the operative factor. With two matched groups of children, an experimental group and a control group, one could admittedly make the position somewhat more uncomfortable for one side or for the other than I have indicated, but there is almost always an escape route if one tries hard enough. To one's opponent, of course, the use of this escape route seems disreputable and unscrupulous; but from one's own point of view it is the only possible course.

By way of analogy we may consider people's differing attitudes to psychical research. An advocate of this 'ideology' takes the matter very seriously if a person in a card-guessing experiment regularly obtains eight or nine correct hits out of a possible twenty-five; someone with a different ideology would not even trouble to challenge the experimental procedure or the statistics, but would merely say that the phenomenon, if genuine, was of no special interest. Once again we have a situation in which one party claims to be in possession of thoroughly important evidence, while the other party simply refuses to take the evidence seriously.

It should be added that many of us are happier when intra-contextual and not ideological statements are involved. The therapist is happiest when discussing his own brand of intra-contextual question with another therapist; the neurologist is happiest when discussing matters with another neurologist, and so on. In general one is happier in getting on with the job than in making confessions of ideological faith, which to one's colleagues are superfluous and to one's opponents seem dogmatic and unjustified.

One final point. When Dr Jaques (1951) called attention to below-surface resentments and tensions which made settlements about wages difficult, he cleared the ground in a very

important way. But even when these attitudes had been made explicit there still remained the reality problem of reaching agreed solutions in cases where there was a genuine conflict of interests. In the same way there are, it seems to me, genuine differences of outlook and standards of value between experimentalists and therapists; we may agree that emotional overlay complicates the issue. We may agree that if someone for personal reasons finds the psychodynamic approach difficult to accept, it is all too easy to use the words 'lack of scientific validation' as a battle-cry for discrediting it. But when the tumult and the shouting have died the experimentalist has still a genuine case which requires to be taken seriously. It is difficult to formulate this case in a way that is free from theoretical objections. What is chiefly involved is the insistence that concepts to be scientifically valid must be capable of 'operational definition', that it must be possible to give them 'cash-value', to use William James's phrase, in terms of experimental results. I do not think we have the right to insist that such results should be specified down to the last detail; but we must know at least in a rough way what would count as validating or invalidating a particular conceptual formulation. In particular we must know *what is being excluded*. A genuine hypothesis is one that 'sticks its neck out' so as to allow the opportunity for proving it wrong. A hypothesis which is compatible with any and every occurrence is scientifically useless.

Now there is a *prima facie* case for saying that certain psychoanalytic concepts (e.g. 'ego', 'superego', 'object-cathexis') are vulnerable in this respect. I have no time to work out the argument in detail, but will limit myself to two examples. When Freud (1915) says 'The system Ucs contains the thing-cathexes of the object', the relationship of this terminology to the actual things which people say and do in analysis is not by any means obvious, to say the least. And when he tells us (1923) that the ego 'is first and foremost a body-ego'—a comment which is continually repeated with

approval by his followers—one is immediately tempted to ask, How does he know this? What observations in the analytic session could conceivably justify or falsify such a claim? I am not arguing that such talk is patently silly; I am saying only that the experimentalist has every right to ask *how exactly* such talk is related to the observed facts, and that if such talk is to be justified at all, a programme of translation must at least be possible in principle. In point of fact I am not sure that all present-day analysts would wish to insist on the need for such talk, and I should like to believe that a person could go through a satisfactory analysis without ever having heard of object-cathexes. But I certainly want to claim that the demand for falsifiability is an important and legitimate part of the experimentalist's ideology, and that when analysts are accused—as in my caricature—of making bizarre and grotesque inferences from totally

insufficient data, this is a genuine difficulty which they ought to take seriously. If they fail to do so, the gap which separates them from the rest of the psychological world will become widened instead of narrowed. Equally I want to maintain that the psychodynamic ideology is 'getting somewhere', and that just because there is not the (relative) certainty of chemistry and physics, it does not follow that the whole approach must therefore be disreputable or irrational. The central problem on the intellectual side is thus the reconciling of two *prima facie* incompatible ideologies, both of which require to be taken seriously.

To sum up: there are genuine problems about validation and there is the emotional overlay which makes a constructive approach to these problems difficult. What I have said in this paper is that the emotional overlay needs to be taken into account no less than do the genuine problems.

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Symposium on psychoanalysis and validation

II. On the Character of Psychodynamic Discourse

By B. A. FARRELL

I wish to examine some features of the complex conflict that pervades the psychological world at the present time, and that is the subject of this symposium. The conflict has various sources. I want to draw attention to one of these, and to offer a diagnostic suggestion which may help to account for some aspects of this conflict.

I

At the present juncture there is widely current a certain view about the nature of scientific method and theory. Indeed, it might even be said to be the fashionable doctrine. I shall call it—misleadingly but for convenience of reference—‘the hypothetico-deductive view’ of science. This view of science is in the text-books in one form or another; it comes in with the flood of transatlantic work and propaganda in the psychological field; and it appears to be the milk which many students of psychology incorporate at the breast of Alma Mater. Consequently, it is a view of science that is well known to psychologists, and I need not stay to outline it.

What I want to do, however, is to draw your attention to a certain consequence that is apt to ensue if one accepts this view of science. If we hold that a procedure is scientific when and only when it exhibits an operational-cum-hypothetico-deductive character, and if, further, we adopt the position that a theory is scientific when and only when it exhibits the character of theories that have been developed by this type of procedure, then we may be tempted unwittingly to do two things. First, we may be tempted to identify procedures, inquiries and theories that are *scientific* with those that are *rational*—that is to say, to make the scientific and the rational mutually co-

extensive. In other words, we may be tempted to make all inquiries, etc., that are not scientific in the hypothetico-deductive sense irrational inquiries and theories, and hence intellectually disreputable. Secondly, we may be tempted unwittingly to suppose that a sharp boundary, or line, can be drawn between procedures, etc., that are rational and scientific in this sense, and those that are not. In other words, that all procedures, etc., fall either on one side of the line or on the other; and that it is relatively easy to tell on which side any example does fall.

Now it seems clear that these two temptations are dangerous and should be resisted. The reason is that they lead us into falsehood. Thus, it is simply not true that all rational inquiries, etc., are also scientific in the hypothetico-deductive sense we are concerned with. For example, the study of history by trained historians is a highly rational business, but it is not a scientific one. Similarly for inquiries such as economics, jurisprudence and the judicial process itself. Likewise, it is simply not true that there is a sharp boundary between procedures, etc., that are scientific, in the hypothetico-deductive sense, and those that are not. Think, for example, of the procedure of ‘field work’, or ‘functional penetration’, used by social anthropologists. This has features that make it resemble objective observational work in a natural science; and yet it also has features that make it quite different from this. Field inquiry is an example that straddles the sharp boundary we may try to draw between a procedure that is scientific in the relevant sense, and one that is not.

Unfortunately psychologists are apt to fall into these two temptations. This lapse from grace becomes serious when they are

confronted by the procedures and theories of psychoanalysis and its cognates. For they are then led, or inclined, to dismiss psychoanalysis quite simply as an unscientific enterprise, and hence as an irrational and somewhat disreputable business. Of course, this way of deciding about the logical character of psychoanalysis has the merits of being brief and clear cut. But it also has critical demerits. It fails to uncover the nature of the problem posed by psychoanalysis and it lands psychologists in paradoxical absurdities—for example, the absurdity of having to dismiss Freud as an unwitting charlatan, and yet having to agree that the magnitude of his contribution to psychological thought is as great as any man's. However, the real irony of this contemporary intellectual scene is to be found, I think, in the fact that analysts, therapists, and others have themselves been affected by propaganda for the hypothetico-deductive view of science. Hence they are themselves inclined to succumb to the inclination to regard their own activity as an unrespectable business and, in consequence, I suspect, to suffer a bit from feelings of personal unworthiness. But, quite naturally, they also have the urge to repudiate this inclination, and to maintain that they are doing something of value and are uncovering material of great psychological interest and importance. It seems clear, in short, that analysts and others are beset by the very same conflict about psychoanalysis that pervades the psychological world at the present time. They appear to have no way of handling this conflict themselves, and to have no generally acceptable rationale of their own activity.

II

I wish to suggest, then, that one source of the difficulty we are all in about psychoanalysis centres round the fashionable view of science. This view inclines us to describe psychoanalysis as an unscientific enterprise, and yet we cannot really accept this description. How now shall we deal with this problem? Fortunately, it is easy today to realise what the

general route is that we have to take. What is not so easy is to deal with the mass of complexities and details we find on the way. All I shall attempt here is to indicate the route and point to the sort of thing we have to do to traverse it.

It seems evident that the *immediate* cause of the trouble lies in our impulse to describe psychoanalytic methods and theory in terms of the standard hypothetico-deductive theory of science. The first step, therefore, that we must take is to resist this impulse. We must resist the impulse to look at psychoanalysis through the spectacles of this or any other theory of science. To succumb to the impulse is to run the risk of misunderstanding and distorting psychoanalysis—of getting its logic quite wrong. What we must do instead—the *general* route we must follow, I think—is to examine the methods and discourse of psychoanalysis and its cognates, as they actually work and function. We must try to look at psychoanalysis unencumbered by any metaphysic of science, in order to try to see in detail how it resembles and how it differs from other disciplines—disciplines such as the advanced natural sciences, biological inquiries, clinical medicine, and so on. We shall then probably be in a better position to decide on the logical character of psychoanalysis, and so to resolve the conflict about it that troubles us at the present time.

Let me now try to give a *glimpse* of the *sort* of thing we discover, I think, when we look at psychoanalysis without using the spectacles of any theory of science. I shall concentrate solely on the *discourse* of psychoanalysis and its relatives. I shall examine this discourse by considering an example of what might loosely be called, if we wish, a psychodynamic explanation of a piece of human conduct. I shall use an example that can be set out fairly briefly, though it is not perhaps really very suitable.

Consider the case of a boy D. He was aged 11 when he arrived at a private preparatory school run primarily for day boys. He soon began to misbehave in class in small irritating ways (e.g. just not doing his prep. in his

exercise books but on any small scrap of paper). He began to misbehave socially by, for example, meting out rough aggressive treatment to the smaller boys, and by insisting on claiming the attention of the young Headmaster on any and every occasion. So mad-dening was he in all sorts of ways that, in the words of one of the staff, 'he nearly drove us all up the wall'.

D's medical history was uneventful. He was a large well-built boy. Mentally he was up to average in the school, but behind in his attainments. He has three other brothers. His parents are somewhat conventional and devoted to their children. At the age of 8 he had been sent to another prep. school. About a year or two after his arrival there, the school suffered a change of Headmaster, and under the new dispensation, boys were beaten regularly for bad work as well as for bad behaviour. The work of the boy D began to get worse under the new régime, which meant that he was beaten more frequently. Finally, at 11 his parents removed him and placed him in his new prep. school where he is at present.

Now let us ask: 'Why did D misbehave in his new school? Why did he nearly drive the staff up the wall?' If we were to press the young Headmaster for an explanation, he might answer us somewhat as follows. 'You ask me why is D being difficult? Well, I suppose it's to be expected. He has just come from a school where the régime is one of 'heel clicking' and 'yes-sirring'; and where he has been beaten for bad work—which upset him very badly. At this school we don't have corporal punishments, and we staff try to maintain discipline by keeping in close and informal touch with the boys, and by getting the boys to feel responsible themselves for maintaining discipline in class and out of it. So when D came to us, he started to live out his bottled up terrors and resentments, which he had picked up at his previous school, by taking it out a bit on some of the younger boys; and we had to protect them. He also started to behave badly in small ways in class and out of it, because he now has the job of learning to

live in a reasonable environment. So he misbehaves in order to try us out—to see how far he can go before he is pulled up. He plagues me in particular in order to try to get the conventional Headmaster's response out of me—which I consistently don't give him. I expect he will soon start following me round cowed with a gigantic crush. But as he finds he is continually treated in a kind but firm and consistent way, he will gradually get over it all, I hope, and in the course of the next year or so live it all out, and become an ordinary member of the school.'

Now this explanatory story is an example of a type that is very familiar to all of us. It offers us what is called 'an interpretation' of D's conduct, and it contains several interpretative suggestions or hypotheses. Let me pick out the hypothesis that D behaves badly towards the staff because he is trying them out. I shall now express that part of the whole explanatory story which is connected with this hypothesis in the following misleading but convenient form.

'Cases of bad behaviour of a certain characteristic type, or sort, are apt to be cases of trying or testing out. The behaviour of the boy D is a case of bad behaviour of this type or sort. Therefore the behaviour of the boy D is a case of trying or testing out.'

Notice that the major premise of this explanation does not contain any quantified properties, and is not universal or statistical in form. In these respects it differs from a type of explanation characteristic in the developed sciences.* If it were to take the form characteristic of these sciences, then it would read as follows.

Either: 'All cases of behaviour with quantified properties P 1 to P_n are cases of behaviour with quantified property Q. The behaviour of

* For standard accounts of explanation in what I have called 'the developed sciences', see K. Popper (1959), and C. G. Hempel and P. Oppenheim (1953). The logic of explanation in psychodynamics, psychiatry, and clinical medicine generally seems to be a neglected subject.

the boy D is such a case. Therefore, the behaviour of the boy D is a case of behaviour with property Q.'

Or: 'The chances of a case of behaviour with quantified properties P1 to Pn being a case of behaviour with quantified property Q is N/M. The behaviour of D is such a case. Therefore, the chances of this behaviour being a case of behaviour with property Q is N/M.'

But the psychodynamic explanation offered by the Headmaster manifestly does not take either of these forms, however much we might wish that it did. Observe in particular that the Head does not commit himself to assert that 'all' cases of bad behaviour of the characteristic sort he is concerned with are included in the class of cases that try out. All he is committed to is the premise that 'cases' of this bad behaviour are liable to be included in this other class. Notice, further, that in the explanations characteristic in the developed sciences, the conclusion follows logically from the two premises. In the explanation of D's conduct it is clear that the conclusion does not follow logically from the premises. The connexion between the premises and the conclusion is that the former gives us reason to believe that the behaviour of the boy D is a case of 'trying out'. Because of this, it is better to express the conclusion of the Head's explanation as follows:

'Therefore, we have reason to believe that the behaviour of D is a case of trying out.'

But by now many of us will be losing patience. An interpretative hypothesis has been offered us, and what we are interested in (we feel like protesting) is this. How does the Headmaster, or anyone else, know that it is true? How can it be verified?

These are very natural questions to come from psychologists at the present time. I want to suggest that they are inappropriate questions and should not be asked. The demand: 'How does the Head know that his interpretation of D's behaviour is true?' presupposes that he *does know* that it is true, and asks him *how* he does so. But when the Headmaster offers this interpretation about D, he does not claim to

know that it is true. He produces it as a suggestion that he thinks is worth considering. And this is characteristic of the way in which psychodynamic interpretations are offered and function. We must therefore re-express the demand 'How do you know?' in some aseptic form, such as 'Why do you believe that...?', or 'What reason have you for thinking that...?' The other demand ('How can the interpretation be verified?') would normally be taken to imply that there is or should be some *procedure* available to us by the use of which we can determine whether the interpretation is true or not. But there is obviously no such procedure open to us; and it is just because there is not one that the Head would look at us blankly if we asked him to verify his interpretation. If, however, we allow ourselves to be engulfed by the demand for verification, we are liable to imagine that, because there is no verificatory procedure available, there are no considerations available at all that can help us to determine the truth or falsity of the interpretation. And this is a mistake. There are considerations at hand which can provide us with evidence and reasons for and against this interpretation of D's conduct.

III

Let us go on to take a look at the sorts of considerations which are relevant to the truth and falsity, adequacy and inadequacy of the Head's interpretation.

(1) It is evident that this interpretation of D's conduct is an attempt to provide us with a *coherent* story of the facts known about D. The specific suggestion that D's bad behaviour is a testing out performance is part of this attempt. It is for this reason that it would be a good objection to the Head's interpretation to argue, for example, that the boy's bad behaviour and bullying of the other boys really has certain features that make him resemble an organic, brain tumour case. This would be a good objection because, in producing it, one would be pointing to features of D's conduct that the hypothesis of 'trying out' cannot fit in or cover. So to be rationally

acceptable the hypothesis of 'trying out' has to satisfy the criterion of 'coherent fit'. I think I am right in saying that an important part of the rationale of the discussion in a case conference centres round the role played by this criterion of coherent fit.

(2) It is evident that certain empirical consequences do follow from the hypothesis of 'trying out'. Hence it is possible for us to throw light on its truth or adequacy by checking the truth of the predicted consequences we can obtain from it. Thus, if D is really trying out, it will follow, for example, that he will develop a strong attachment to some adult in his new school. As the Head said: 'I expect he will soon start following me round cow-eyed with a gigantic crush'. If the predicted consequence occurs, the interpretation is confirmed in some measure; if it does not, then some doubt is cast on the interpretation. But, I think I am right in saying, the way this prediction is derived from the interpretative hypothesis differs logically from the way in which predictions are characteristically derived in the developed natural sciences. I shall not elucidate the differences here. But it is perhaps a sense of this difference that leads analysts, therapists, and others to avoid talking about predicting in this context, and to express their predictive claims in alternative locutions, such as: 'expect that the boy D will. . .', or 'hoping that. . .', or 'looking forward to. . .', and so forth. Loose and informal as these locutions may sound, it is important not to overlook the predictive claims embedded in them. Their relevance is quite considerable, since to offer an interpretative hypothesis is, in part, to imply that all further discoveries about the person or patient will not upset the interpretation, but will either support it or be consistent with it.

(3) For the Headmaster's interpretation of D to be rationally acceptable, it must provide us with a story that is not inconsistent with the existing rational corpus of knowledge on the whole subject. Suppose that D's conduct could be explained quite differently—in terms, let us say, of a well-known syndrome of incipient psychosis in the pre-adolescent. Then

the Head's story would clash with this well-known alternative, and this would count against the truth or adequacy of his suggestion that D was trying out. Furthermore, of course, if the Head were unwise enough to suggest that his story about D were *sufficient* to account for D's bad behaviour, he would be flying in the face of existing knowledge. For we know very well that not all children with D's school history will exhibit bad behaviour when transferred to a more liberal environment. (Indeed, there are at present three other boys at this particular school who have also been transferred there from the beating establishment. But none of these exhibit D's type of difficulty.) It seems clear, therefore, that to the extent that the Head's interpretation satisfies this criterion of consistency to that extent does it gain in weight or plausibility.

Which brings us to a related consideration.

(4) The Headmaster's interpretation and 'trying out' hypothesis seem to carry with them an air of initial plausibility; and to many of us they will seem to have a good deal of weight. Why is this? Largely, no doubt, because they do not stand alone. If the story and the hypothesis about 'trying out' are challenged, it is possible to defend them by showing them to be the application of an elaborate and technical theory of, or way of talking about, human functioning. Indeed, if one defends them by using this theory in its classical Freudian form, then it may be possible to go even further. It may be possible to show how the major premise I exhibited ('Cases of bad behaviour of a certain sort are apt to be cases of trying out') is itself explicable in terms of the more fundamental propositions of the theory. Now whatever weight this theory, or some cognate one, possesses is passed on to any application of it. Hence the Headmaster's story and hypothesis carry with them the weight of the theory of which they are an application. But even the most hardboiled among us will admit that 'Freud is obviously getting at something'. This is an admission—off the psychological record!—that the relevant theories have some weight. Consequently the Headmaster's story and hypothesis come to us with the force of an

explanation that is initially plausible. If, at this juncture, we wish to pursue our examination of the truth or adequacy of the Head's interpretation, we can do so by moving over into an examination of psychoanalytic theory itself—its logic, the weight to be attached to relevant parts of it, including those parts that supply the major premise of the explanation: 'Cases of bad behaviour of a certain type are apt to be cases of trying out'.

IV

I have now pointed to some of the considerations, or criteria, that bear on the truth or adequacy, or otherwise, of the Headmaster's interpretation of D's conduct. This demonstration carries with it one or two obvious morals and implications.

Even if the Headmaster's interpretation were to satisfy the criteria I have sketched out, it would only achieve a somewhat low level of—what one might call—'satisfactory proof'. This level of satisfactory proof may be much lower than the one used and required in, say, experimental psychology. If it is much lower, if it does differ in this way from the level used in experimental work, then the moral is clear. We must all—and experimentalists in particular—avoid the mistake of criticizing any *particular* interpretation on the ground that the evidence in its favour does not reach the level of satisfactory proof required in experimental psychology. Remember: to each type of discourse its own logic. And this includes the logic of proof and evidence.

Let us remember, too, a related characteristic of psychodynamic discourse. Though the level of satisfactory proof reached in it is low, it is the discourse we usually find ourselves forced to use when we try to give a psychological explanation of an individual case or episode, such as the boy D. In contrast, the level of satisfactory proof required and reached in the discourse of experimental and objective psychology is much higher than that reached in psychodynamics. But the discourse of experimental and objective psychology is

also generally much less useful than that of psychodynamics when it comes to giving an explanation of an individual case. In this area the discourse of the experimentalist and objectivist is marked by its relative inutility.

The Head's explanation of D's conduct draws our attention to a critical peculiarity of psychoanalytic theory or discourse, and its cognates, namely, that it contains important generalizations that are not universal or statistical in character. These cluster round what has been called the Mechanisms of Defence. The peculiarity of these generalizations is that their truth conditions are uncertain, and that a negative instance has little refuting force. If, for example, the Head's predictions about the boy D are not borne out, he may be logically obliged to withdraw or modify his explanation. But he is not logically obliged to withdraw or modify the theory which he used to explain D's conduct. It would still be quite reasonable for him to continue to assert that 'Cases of bad behaviour of a certain type are apt to be cases of trying out'. The immediate implications of this is plain. When we try to investigate the truth of psychoanalytic theory by experimental and similar methods, the logic of our investigation will depend on what part of the theory we are studying. If we are investigating the psychoanalytic story about, say, the stages of mental development, we shall be concerned with universal generalizations. But if we are looking into the phenomena of regression, fixation and the like, we shall be primarily concerned with generalizations of a different character. The logic of this difference produces complications for the objective investigator of psychoanalytic theory—complications about whose character and consequences I am still unclear.*

* For generalizations that are neither universal nor statistical in form, see B. A. Farrell (1949) and R. B. Braithwaite (1953). The logic of the confirmation of psychoanalytic hypotheses is touched on in Farrell (1951). But this paper blurs the distinction between generalizations that are universal or statistical and those that are not; and it is misleading in consequence.

In this paper I have considered, in a sketchy manner, an example of psychodynamic explanation. I set out to do so in order to try to give a glimpse of the sort of thing we discover when we look at the way this type of discourse actually functions—unencumbered by any metaphysic of science. I hope I have been able to say enough to help us to inhibit our immediate impulse to describe psychodynamic discourse in terms of the fashionable hypothetico-deductive theory of science. I hope also that, by my outline of psychodynamic discourse, I have succeeded in another thing: giving a little insight into some of the features of the discourse that generate the conflict we are

concerned with in this symposium—the conflict over the scientific status of psychoanalysis. The long-term goal of psychologists in this field is to make the discoveries that will enable us to transform the discourse of psychodynamics into a discourse of the more efficient type used in the developed natural sciences. In the attempt to achieve this goal, it is obviously advisable for us to be as clear as we can about the logic of the enterprise. And to achieve clarity, it is necessary to free ourselves from the suffocating atmosphere of mutual misunderstanding, religiosity, and passion that usually surrounds the problem we are considering.

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Symposium on psychoanalysis and validation

III. On the 'Clinical' and 'Objective' Approaches to Psychodynamic Material

By D. H. MALAN

Mr Miles's paper dealt with some of the emotional reasons, and Mr Farrell's with some of the intellectual reasons, for the wide divergence in views and difficulty of communication between psychotherapists and experimental psychologists. The present paper will be concerned with the corresponding divergence between methods of studying psychodynamic material.

As Mr Miles has implied, there are two extreme approaches to psychodynamic data, which we may call the 'clinical' and the 'objective'; and as both authors have emphasized, neither is wholly satisfactory—the 'clinical' because (to quote Mr Miles) of apparently 'bizarre and grotesque inferences from totally insufficient data'; and the 'objective' because (to quote Mr Farrell) of its 'inutility'. My theme will be that the wide gap between these two approaches can be greatly reduced by modifications, not at one end, but at both; and that were it not for the emotional problems with which this subject is beset, these modifications are so obvious that they would have become part of standard practice long ago.

The 'clinical' approach to psychodynamics stems largely from the psychoanalysts, who were originally forced to develop their ideas in isolation because of intense emotionally based criticism from the outside world. This resistance against unpalatable and disturbing explanations of mental phenomena is almost certainly still a major factor. But the isolation of psychoanalysis has its dangers, and there are certain criticisms—whether emotionally based or not—which may possibly deserve to be taken seriously. One such criticism concerns the relation between psychoanalytic evidence and the conclusions drawn from it.

The following question must first be considered:

What, in the most general terms, are the rules of evidence to which a science may be expected, *as far as possible*, to conform? They may perhaps be stated as follows:

(1) Data should be published in such a form that an independent observer can judge it for himself.

(2) Alternative hypotheses should be considered, and either some attempt made to choose between them on the evidence already available, or some suggestions made about evidence which might be obtained in future work.

(3) If conclusions are reached: (a) some attempt should be made to consider fallacies and if possible to exclude them; and (b) there should be a clear realization of the extent to which the conclusions seem to be the natural and inevitable explanation of the data, and the extent to which they are the author's own choice—in other words based on speculation.

Now the words italicized above, '*as far as possible*', are very important. There is no question that the subject of psychodynamics presents very special difficulties to the scientific investigator. In particular, there are at least three serious and quite independent difficulties in the way of publishing the evidence: (1) its enormous volume, (2) its intangible nature, and (3) the fact that it is confidential. The third of these difficulties was especially important in the conditions in which Freud and the early analysts worked, and such remarks as 'Motives of discretion impose a great deal of reserve in the publication of my psychoanalytic material' (Abraham, 1924), can be in no way open to criticism.

Now that psychoanalysts are no longer

confined to small and tightly knit communities, however, this particular difficulty is much less serious. It is my view, also, that the other two difficulties can be at least partly overcome, and that insufficient attention has been paid to this precisely because psychoanalysts have not been fully aware of the necessity to do so.

This statement is most conveniently supported by quotations from other psychoanalysts trying to express a similar point of view. The following is a quotation from Edward Glover (1952):

'An analyst... of established prestige and seniority, produces a paper advancing some new point of view or alleged discovery.... Some few observers who have been stimulated by the new idea may test it in their clinical practice. If they can corroborate it they no doubt report the fact; but if they do not, or if they feel disposed to reject it, this scientific 'negative' is much less likely to be expressed... and so, failing effective examination, the view is ultimately canonized with the sanctioning phrase, "as so-and-so has shown". In other words, an *ipse dixit* acquires the validity of an attested conclusion on hearsay evidence only.' (A somewhat similar point of view is expressed by Wlder (1937).)

The use of words such as 'show', 'discover', 'finding', 'observation' is quite a common feature of psychoanalytic writing. These are the words used in the exact sciences for describing definite experimental results and undoubted conclusions—this applies in particular to the German '*zeigen*' as to the English 'show'. However, these words tend to be used by psychoanalysts not only in this sense, but also in order to describe hypotheses, conjectures, and theoretical constructs which are still speculative, inadequately tested, or controversial.

It is important to point out that the tendency to use these words inaccurately long preceded the new controversies in psychoanalytical theory and practice to which Glover and Wlder probably refer. The tendency is not, I think, found in the writings of Freud himself, but it is to be found in those of some of the

other early analysts. The following is a single example, which I have done my best to check, though it is always possible that there are factors which I have overlooked. It is chosen, among many reasons, because it comes from the writings of Abraham, whose scientific integrity no one can doubt.

In Freud's famous paper 'Mourning and Melancholia' (Freud, 1917), a hypothesis was put forward about the psychopathology of self-reproaches in melancholia in the following words: 'If one listens patiently to a melancholic's many and various self-accusations, one cannot in the end avoid the impression that often the most violent of them are hardly at all applicable to the patient himself, but that with insignificant modifications they do fit someone else, someone whom the patient loves, or has loved, or should love. Every time one examines the facts this conjecture is confirmed. So we find the key to the clinical picture: we perceive that the self-reproaches are reproaches against a loved object which have been shifted away from it on to the patient's own ego.' No actual clinical examples are given in this paper at all.

In a paper published by Abraham in 1924, Freud's 'one cannot avoid the impression that' becomes the following: 'At about the same time Freud... showed (German: *zeigte*) that the patient, after having lost his love-object, regains it once more by a process of introjection (so that, for instance, the self-reproaches of a melancholiac are really directed towards his lost object).'

Now, although Abraham goes on to give some quite convincing evidence in favour of Freud's theory, his use of the word 'show' suggests a tendency which I believe to be widespread in psychoanalytic thought, namely the failure to distinguish clearly between hypothesis and established conclusion.

At this point the question must be asked, how directly is it possible to test psychodynamic hypotheses? This leads to a consideration of scientific method in general. Sciences can be arranged in a sort of hierarchy according to how rigorous and direct are the

methods of investigation available. Not even the experimental method—often felt to be an essential characteristic of a science—is available always. It is important that we should realize the correct place of psychodynamics in this hierarchy, and neither try to put it too high nor be content with leaving it too low.

We may illustrate the hierarchy by two extreme examples, and one that is intermediate. There is no need to enumerate the characteristics of a science at the upper end of the hierarchy, such as physics. We all know, and too easily take as our model, the use of exact quantitative methods, the ability to perform exactly repeatable experiments, etc., etc.

As an example from the lower end of the hierarchy we may take the theory of evolution, and here we find some extreme contrasts. Not only is the theory in itself largely qualitative, but even quantitative methods of investigation have played a relatively minor part. Moreover, past evolution is a unique event which can never be observed or influenced; and evolution takes place so slowly that it is hardly possible to observe or influence future evolution either. Thus, here, direct experiment can play little part, and we are forced to rely on evidence which is 'circumstantial'. Yet no one would say that the theory of evolution is unscientific.

In between these two comes a science such as plant ecology. This is in part concerned with processes of development—of plant communities—somewhat analogous to evolution; but, because of a comparatively trivial difference, namely in the time scale, we are able to influence these processes, and thus to perform direct experiments. Thus, much circumstantial evidence can be accumulated in favour of the view that, in Britain, chalk grassland has a tendency to grow into scrubland and eventually into beechwood, and that this tendency is only held in check by grazing, particularly that of rabbits. But the evidence does not stop there, for, if rabbits are excluded, the colonization of the grassland by woody plants can be observed directly.

The question is where psychodynamics

stands in this hierarchy. Mr Miles has emphasized that physics and chemistry are not the correct models for psychodynamics. But is the theory of evolution? The answer is surely no. The methods available in psychodynamics place it far above evolution, and much more on a level with ecology. In psychodynamics we have the enormous advantage that, in consequence of the very act of uncovering the past, the processes of development in a patient are changed; it is thus possible to intervene and to study the effects of our intervention, in other words to perform 'experiments'. As Ezriel (1950, 1951) has emphasized, the central 'experimental' fact of psychoanalysis is the *effect of interpretation*.

In view of this, it might be possible to lay down criteria, analogous to 'Koch's postulates' in bacteriology, by means of which certain types of psychodynamic hypothesis could be tested. The theory of self-reproaches in melancholia may be used as an example. A psychoanalyst who took a melancholic patient under treatment could make a record in advance:

- (1) of the self-reproaches;
- (2) of the loved person towards whom these reproaches were probably unconsciously directed; and
- (3) of the suspected true nature of the reproaches when all unconscious distortions and symbolizations had been removed.

The analyst could then try not to give the interpretation of the self-reproaches too soon or too often, but to wait until he felt the patient was ready; and to record as best he could, on each occasion, the patient's immediate response and certain relevant subsequent events, namely:

- (1) expressions of anger;
- (2) the intensity of self-reproaches; and
- (3) the depth of the depression.

Ideally, what should be observed, at least in a proportion of cases, is:

- (1) the release of anger against the originally named loved person;
- (2) a weakening of the self-reproaches; and
- (3) some lifting of the depression.

All three phenomena should become more marked, and (2) and (3) should become more permanent, as the analysis proceeded. The whole would then become a series of experimental observations which require explanation. It is now very important to realize that the true explanation is not necessarily the simplest, namely that the interpretations are exactly correct as given. There should follow a discussion of alternative hypotheses and some attempt to exclude fallacies.

In fact it is observations of this kind, made consciously or half-consciously, that are used in every analysis for testing whether an interpretation is useful or not. Moreover, such observations are of course often reported; but they are rarely reported systematically, and they are even more rarely reported as observations for which several alternative hypotheses may provide the explanation.

Yet to the 'experimentalists' in turn the following needs to be said: that the observations of psychotherapists are real observations, of strange and unexpected phenomena, which have to be taken seriously, which require explanation, and of which the explanation may well be as unexpected as the observations themselves. Anyone who has worked in interpretative therapy must be aware of the extraordinary power of the forces with which he is working, and particularly the power of interpretations based on dynamic theory. When, as has happened to me, I make the seemingly harmless remark to a patient that he is afraid that I, like his father, will criticize him for being a nuisance to his mother, and he is immediately precipitated into a confusional state—this is an observation which requires some kind of explanation, and one of the possible explanations is, to put it at its lowest, that the patient does have severe anxieties about his relation with his parents which he has transferred on to his therapist.

In short, the justified criticism of psychodynamics is not that it is in essence unscientific, or unfalsifiable, or whatever similar term you like to use, but that its potential as a scientific study has not yet been realized.

So far the approaches considered have been entirely qualitative. The question now arises whether quantitative studies can also play a part. Many workers believe they can, though of course only in certain types of problem. In such a complex subject, this often means the use of statistics.

It is perhaps here that the greatest possibilities lie for a coming together of the 'clinical' and 'experimental' approaches. At the two extremes, each approach by itself has advantages and severe disadvantages. If we keep the two extremes separate, there is the great danger that we will either reach clinically valuable conclusions without valid evidence; or reach, by impeccable evidence, conclusions which are clinically of no use at all.*

It is quite obvious that a small amount of statistical thinking would enormously help the clinician and sometimes save him from absurdity—for instance by making him consider the probability of obtaining a given result by chance alone, or the problem of 'controls'. At the same time, every statistician knows that pure statistics is a blind servant, liable to lead him into serious error unless he brings in reasoning derived from an intimate knowledge of the subject he is studying. This means that he needs the help of the clinician.

An example of, in my view, the fallacious use of a quantitative method is as follows:

Harris (1954) published a comparison of the recovery rate in patients treated (1) by psychotherapy, (2) by CO₂ abreaction, and concluded from the figures that there was little difference between the two. He tried, quite rightly, to use as objective criteria as possible, and one of those that he chose was whether or not the patient was able to go back to work. This is, of course, a thoroughly objective criterion, yet its psychodynamic validity is greatly open to question. All analysts are familiar with the phenomenon of 'flight into health', a mechanism by which the

* This view was put forward very clearly by Dr Helen Sargent (1957).

patient represses his symptoms in order to avoid facing his anxieties, and which may involve adopting severe restrictions in his life to avoid anxiety-provoking situations. 'Objective' though the criterion of return to work is, therefore, it can be said to be clinically of doubtful value.

The question is, how could better criteria be devised—criteria which are both reasonably 'objective' and yet clinically meaningful. There can be no question that there has to be some sacrifice of objectivity, but I do not think a solution is impossible. The following is an outline for a project which one day I hope to study:

According to psychoanalytic theory, hysteria in women is at any rate partly caused by sexual anxieties. In fact it is found that many hysterical women are also frigid. It seems reasonable to suggest that the frigidity is a more direct expression of the sexual anxiety than are the hysterical symptoms, and consequently is likely to be a better indicator of whether the sexual anxiety has really been resolved or not. Now it is known that quite a high proportion of neurotic patients eventually lose their presenting symptoms whether they are treated or not. If one compared the proportion of patients that lost their hysterical symptoms in a treated and untreated series, one might well find little difference. The conclusion that psychotherapy is valueless is only too easy. But what would be the result if one compared the proportion in the two series that lost both their hysterical symptoms and their frigidity? No one knows, but the answer would be more relevant to the question of the value of psychotherapy.

In summary, if the clinician has to learn from the experimentalist how to pay attention to the simple rules of evidence, the experimentalist has to learn from the clinician how to study, by these rules of evidence, factors which are clinically relevant and meaningful. And if the emotional resistance could be overcome on both sides, the potentiality for doing this in a quite practicable way would be very considerable.

This process of reconciliation has of course already started, e.g. in the ambitious research project of the Menninger Foundation (Wallerstein, Robbins, Sargent & Luborsky, 1956) by which my views have been considerably influenced, and the publications of Sandler and co-workers (e.g. Sandler & Hazari, 1960), and many others.

In conclusion I will discuss ways of studying a type of problem concerned with Brief Psychotherapy. This subject has been under investigation for a number of years by a team of psychoanalysts, of which I am a member, under the leadership of Dr Michael Balint. One of the questions at issue is the technique which is appropriate in this kind of therapy. An answer to this question must depend on some kind of study of the relation between 'outcome' and the different kinds of technique used in different therapies.

Now Brief Psychotherapy has the very great advantage over psychoanalysis that the material, though voluminous and complex enough, is not quite impossible to handle in its entirety. The following kind of study is therefore possible in principle:

(1) The rating (by independent judges) of 'outcome' on a scale based on dynamic theory.

(2) The tape-recording of all sessions.

(3) The classification of 'interpretations' into broad categories, e.g. 'transference' and 'non-transference', and the making of a judgement (by several workers independently, and independently of those in (1) above) about each interpretation in the records.*

(4) The calculation of the proportion of, say, 'transference interpretations' in each therapy (this proportion to be called the 'transference ratio');

(5) The study, by inspection or by a statistical method such as Kendall's τ , of the relation between the value of the 'transference ratio' and 'outcome' for the therapies under consideration.

* The idea for this was originally suggested by the writings of Strupp, the latest of which is Strupp (1960).

Now there are two kinds of opinion about such a study. On the one hand, since—for all we know—a single correct and well-timed interpretation may be all that is needed, and therapists may persist with incorrect or inappropriate interpretations for hours, any correlation between outcome and a purely quantitative measure of interpretation might well be thought to be clinically meaningless. On the other hand, a possible view is that, though the clinical meaning would by no means be clear, the results might well be of interest.

In fact this rigorous approach was quite impossible in a study carried out by therapists in their spare time with no special secretarial help. The raw data consisted, therefore, not of tape-recordings, but of accounts of the sessions dictated with varying degrees of thoroughness from memory; and judgements concerning both interpretations and outcome were made by myself working alone. The only sense in which the study was 'blind' was that the therapists, though aware of some of the hypotheses to be tested, were unaware of the method to be used for testing them.

The use of clinical records of this kind converts a hypothesis of the type 'the greater the quantitative emphasis on certain kinds of interpretation in the *therapy* the more favourable the outcome', into a hypothesis of the type 'the greater the quantitative emphasis on certain kinds of interpretation in the *clinical record*, the more does this record tend to be that of a successful therapy'.* The clinical significance of any evidence obtained has then to be considered.

The aspect of this study which is most relevant in the present context is simply that preliminary results, if they are to be believed, provide evidence in favour of hypotheses which make sense clinically, and indeed which are very similar to principles of technique long established in psychoanalysis. There is of course the great danger of fallacies arising

* A similar (qualitative) study has been carried out independently by Vosburg (1958).

from the fact that the clinical records are highly selected, and the selection itself has been carried out by psychoanalysts. In confirmation of this, there is ample evidence from our work that therapists record more fully when they are satisfied with what they have done, i.e. presumably when they have given interpretations which obtain a marked response and which fit in with their own psychoanalytic preconceptions. This may well be part of the reason why a purely quantitative measure of interpretation appears to have clinical meaning. But in fact this is not so great a fallacy as it may seem: if clinical records containing a high proportion of certain kinds of psychoanalytic interpretation tend to be those of successful therapies, then when a therapist thinks his work is going well *because of the kind of interpretation he is giving*, it is in fact going well *because follow-up shows that the patient tends to get better*. In other words the argument is not circular. A further explanation for the apparent clinical usefulness of the purely quantitative measure is quite simply provided by the well known phenomenon of 'working through'—the necessity for repeating interpretations many times before they have any permanent effect.

There is a further obvious fallacy that it is hardly difficult for a single observer to make a series of individual judgements which together confirm his own over-all judgement. For this reason I do not want to claim any more than that the method, far more rigorously carried out, is not so absurd as it may appear to be, and deserves further investigation.

To return to the original theme, there is a possibility that the quantitative study of clinically meaningful variables may provide evidence about hypotheses of clinical value. If this is so, then the clinicians and experimentalists may be brought closer together; and the two in combination may be enabled to do valuable work in this field which is so immensely important and so appallingly difficult to study.

SUMMARY

The theme of this paper is that the gap between the 'clinical' and 'objective' approaches to psychodynamic material is far wider than it needs to be, and can be greatly reduced by simple modifications at both ends. 'Clinical' judgements when once made can

at least be treated rigorously, and 'objective' variables may have to be modified by clinical judgement to make them clinically meaningful. An exploratory study from the work of Dr Balint's team on Brief Psychotherapy is quoted, in which the two approaches are combined.

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Group processes and the individual in the therapeutic group*

BY S. H. FOULKES

The disturbances, psychoneuroses in the broader sense, with which we are concerned in psychotherapy go back to experiences in childhood which have been repressed. Repression and other defence methods, which are subordinated to it, keep the repressed from becoming conscious. At the same time the tendencies against which the defence is directed are split off from the ego. This defence, albeit a function of the ego, is itself unconscious and also has its roots in the earliest months and years of development. This dissociation or splitting-off from the ego has still another significant sequel: the particle of mental life which is thus isolated assumes again the primordial, archaic, primitive character of early mental life. It is subjected to the primary process and liberated from the straightjacket of rational, reasonable thinking. Belief in omnipotence, superstition, magical thinking, which we trust to have surmounted in waking life, return into their age-old rights. It is the language of delusion and dreams, if you like, but also that of art and religion. What we meet as a symptom is the expression of elementary impulses which have succeeded in penetrating again to the ego, in a way breaking into it. The defensive war against these instinctive impulses in which the ego has been engaged, particularly under the pressure of the superego, the primitive, unconscious internalized conscience, has resulted in a compromise, namely the symptom. The instinctual impulses which are disallowed must not even now show themselves in their true nature, naked as it were, but go about under disguise and put up with all sorts of distortions. The solution of these distortions, displacements, condensations, etc., their uncovering,

* Given to the Medical Section, British Psychological Society, 25 May 1960.

naturally makes up an important part of psychoanalytical work, which thus opposes a powerful part of the ego and superego. For this reason, these defending forces regularly turn as resistances against analysis and the analyst, and the observation, interpretation and dissolution of these resistances becomes at least as important a part of psychoanalytical treatment as the uncovering of the Unconscious itself. Naturally, all symptoms root in the matrix of the personality and its development, so that every analysis has in fact the total personality as its object.

We have therefore to deal with conflicts which are unconscious. Without such a concept of an Unconscious we cannot understand them, nor can we get hold of them without a method which permits us to make the Unconscious conscious. We have said, however, that these conflicts are old, that they are the internalized results of painful, traumatic, undigested and unintegrated childhood experiences and constellations. There would be no hope for us therapeutically but for three circumstances which come to our rescue, and which are of the greatest significance.

(1) Such conflicts only occupy us if they are still active in current life.

(2) They arose in relationship to other people, originally family members or their substitutes, in interaction with them. Even now, when they become active again, this is still true.

(3) Just as the most essential and basic conflicts are compulsorily repeated in life, so they are, in pure culture, under the conditions of the analytic situation (the transference situation).

At this point we cannot enter further into the way in which psychoanalytical treatment makes use of and deals with these circum-

stances. This we must, up to a degree, presume to be known, as we turn towards group psychotherapy, armed with the knowledge and experiences which we have gained as psychoanalysts.

Group analysis, however, is far more than merely an application of psychoanalytical principles within the group. Its particular therapeutic possibilities, which are quite considerable, are due to the fact that we work in a group situation. As we turn now to group-analytic psychotherapy let us start from the second of the aforementioned fundamental conditions as regards our therapeutic efforts, namely, that the actual pathogenic conflict again involves—as did the original one—a number of persons.

It is my belief that in the outbreak of the actual neurotic disturbance of the individual, which after all is the real object of our treatment, a whole circle of people are again actively involved, people who are very intimately connected with one another and, moreover, this is a *regular* occurrence. It is true that they know very little of their interaction in this respect, and that they do not wish to know about it either. I am inclined to ascribe to these observations a greater and more fundamental significance than does psychoanalysis, having as its object of study one- and two-personal dimensions. I have become more and more convinced that the patient whom we see is himself only one symptom of a disturbance which concerns a whole network of circumstances and persons. It is this network of interacting circumstances and persons which is the real operational field for effective and radical therapy. Perhaps it would be more correct to say that this will be so in the future. This would be group therapy in a natural group with the persons primarily involved in the conflict themselves as members of the therapeutic group. Under present circumstances it is very difficult to put such a multi-personal therapy into operation. It would be necessary for this work that it could be shared by a team of therapists who would have to be trained in both psychoanalysis and group

analysis. So far my efforts here in London have not been more than occasional sketchy experiments; they have, nevertheless, given impressive testimony for the forceful and sometimes explosive strength of such a method of approach. I will give here some examples.

(1) The man concerned, A, had been an in-patient before being sent to us. Separation from his wife was imminent. We encouraged his wife A1 to come for treatment as well, and decided to treat the couple in one common shared situation. The therapist consulted me with a difficulty. It had become apparent that the couple repeated their conflict in the treatment situation by pulling him in opposite directions. I advised the therapist to interpret this behaviour to the couple. Only a day or two later I was called to the telephone by a practitioner, PB, who insisted on speaking to me personally. He turned out to be neither the patient's nor the patient's wife's doctor, but the doctor of the wife's sister, B, and seemed rather upset. It was obviously this sister—his own patient—who had stirred the whole matter up. He said that the wife's general practitioner, PA1, had been rather astonished that his patient, Mrs A1, had been taken on for treatment at a Psychiatric Clinic. How could she be asked to be treated in one room with such a man as this (her husband)? Although the practitioner (PB) accepted my explanations and quietened down, he nevertheless asked my approval that his patient B's sister A1 should be sent elsewhere for treatment. Thus the therapeutic situation with my registrar had been broken up, which corresponded to A1's resolve to make an end to the marriage. The therapist, when I told him about this conversation, confirmed that the sister played a considerable part in the conflict, and was not surprised at her reaction. We have, by the way, in a number of instances been quite successful with the joint analytic psychotherapy of such couples, and have also twice had groups of four such couples which seemed to go a long way towards resolving their troubles; but for this type of treatment to be indicated, it seems to be a precondition that the couple concerned

are seriously willing to preserve their marriage. Of course a group such as a marital couple is a very simple example of what I have in mind. What I want to demonstrate here is the subtle but intensive reaction by the whole of the network; the therapist with his technical difficulty, the couple under treatment, the wife's doctor, and the wife's sister and her doctor. All of them, as if by arrangement, became actively involved in the treatment situation. Treatment would have to take this total multipersonal network of disturbance as its object.*

(2) A man had not been working for many years and was unable to go out alone. His symptoms began at the time of his marriage, although there was ample evidence of childhood neurosis (enuresis, nailbiting), sexual problems (manifest castration fears in connexion with intercourse and fear of causing pregnancy, coitus interruptus), and somatic symptoms. In individual treatment, to put it into his therapist's terms, he had improved so much that he could now allow his wife to go out to work. A little later, when he continued his treatment with another registrar he improved further, but just at that time a reaction on the part of his wife became noticeable. It was decided that the wife should be taken on by another registrar of the unit. He reported that the wife's reaction was indeed strong, that she had developed an anxiety state with panics. She had insight into the fact that she could not bear the husband's increasing relative independence from her. She was a 'mother' to him, was so happy while he was helpless, and wanted him ill again. In other words, she could not bear the improvement brought about by her husband's treatment. You see that in this case we have a different situation, the more conventional one, in which a couple is treated by two different therapists. Presently a more difficult situation arose; the wife presented some unexpected features of a paranoid type of jealousy, suspecting her husband of infidelity. (Her mother's death was indirectly due to

shock in connexion with father's infidelity.) On the other side, in the husband's treatment, it emerged that he had started relations with a newly married woman in his neighbourhood. It was psychologically clear that this affair was in no way independent of his wife's jealousy. One can easily see the outlines of this network. Here is a couple plus a couple of therapists, plus another married couple intimately interconnected in the ongoing dynamic process. This situation shows another difficulty, this time arising from separate treatment.

Let us glance back for a moment to the ordinary method of individual psychotherapy as it is predominantly practised today; the husband's progress would have come to a standstill, the therapist being only dimly aware of the wife's reaction. This would remain entirely behind the scenes. We are not always in the happy position of being able to do what we did in this case, to take the wife for treatment as well, but as we can see even that is not enough.

Had the husband and his wife been treated at different hospitals, the wife's therapist would not have known the factual background of the wife's complaint and suspicion, nor would the husband's therapist have known of the wife's deep reactions. Fascinating technical and dynamic problems now present themselves. If we bring them together into the same room for treatment the facts must be brought out into the open. This might well explode the whole marriage. On the other hand, if this cannot be done, or must not be done, then there are obviously severe limitations to treatment.

Before presenting a further example from a group-analytic group I want to make a few comments here.

(a) This type of interference on the part of the multipersonal network is very characteristic and a regular occurrence. It happens always at critical points in the treatment situation, particularly so when a dynamic move towards improvement and liberation is in evidence (e.g. resolution of over-dependence).

(b) The group situation highlights this critical problem in a dramatic manner. In our

* Cf. Main, T. F. (1957). The ailment. *Brit. J. Med. Psychol.* 30, 129, for a beautiful study of such interaction.

last example the group situation makes the central issue of this whole marriage at once evident and inescapable, in that it poses the question of bringing into the open the husband's infidelity, so crucial for the pathological dependence on each other, and the wife's paranoid reaction. This is the case whether we are dealing with natural groups or group-analytic transference groups, and supports us in considering our transactions in the treatment room as significant for the patients' current lives even if we are not always aware of these concomitant implications. Our example also demonstrates beautifully that these current conflict situations are at the same time new editions of Oedipal and pre-Oedipal conflicts.

(3) The third example comes from a group-analytic group in which a woman, 'the daughter', is a member. This daughter showed considerable improvement until her mother entered the field and approached the therapist with the suggestion that her daughter should have psychoanalytic treatment. Two friends of the mother were under psychoanalytic treatment. The mother's interference was in turn characteristic for the daughter's preferred defence. She maintained a relationship with her mother which in recent years has been given the name of projective identification. The therapist did not refuse to see the mother, but insisted on seeing her and the daughter together, and this changed the situation. The mother withdrew and the daughter developed considerable insight into her dependence. It is interesting to note that *in the same group and at the same time* another patient who had shown considerable improvement unconsciously provoked a similar interference from outside. A psychiatrist who had at one time treated this patient, and the doctor of the patient's mother, together exerted pressure and influence that he should leave the group and be treated as an in-patient. We did not see any reason to influence the patient in this direction. When I remarked in supervision that it seemed from what I heard as if the psychiatrist and the mother were personally involved, this was borne out. Here we have two other simple

examples of such a network influence. That two such incidents happen at the same time is by no means accidental, but is meaningful within the context of this group. Again this reaction on the part of ostensibly outside figures comes at the moment of improvement.

This type of group psychotherapy is of particular significance in the consideration of the importance of the natural group network for the pathogenesis and cure of the individual neurosis, but I cannot enter into it further on this occasion.

Group-analytic psychotherapy, as we usually practise it, approaches the same problems from the opposite direction. For this group it is essential that its members, perhaps seven or eight persons, should be strangers to one another. There must be no dependence on one another in actual life, so that their feelings, their attitudes and their actions (or at least the tendencies to such action) can be expressed freely without any fear of consequences in external reality. As in all analytic situations gross action, such as physical attack or the taking up of sexual relationships, should be avoided. Contact between the members must also, as far as possible, be confined to the therapeutic session. Only under these conditions is it possible to maintain the request for frank disclosure and communication. Under such conditions the spontaneous ideas of the patients become the group equivalent of free association. Everything that happens, everything that is said, may be considered to have meaning in the total mental fabric of the group (collective or group association). The contributions of the individual participants also assume the function of unconscious interpretations. The group-analyst at any rate has the right to look upon them in this sense, and in this way he can help the group to understand what they themselves are unconsciously saying and indicating. My observations have shown that even in quite ordinary life groups one can discern these associative components. But the very existence of real purposes, of dependencies, of the necessary caution life brings with it; in short simply everything that we rule out for

our purposes, covers over and confuses these inner links. Though verbal communication is indispensable for analytic purposes, non-verbal communications such as facial expressions, gestures, attitudes and behaviour are at least as important. Such a group is therefore, in the first instance, obliged to translate symptoms into their meaning and to transform the driving forces which lay concealed behind them into emotions, desires and tendencies, experienced in person. While doing so the members learn a new language, a language which had previously been spoken only unconsciously. In this way the capacity for insight and communication grows. The analysis of resistances, defence reactions, and the manifold distortions, further promotes the depth and breadth of what is thought, expressed and understood (in short, everything which can be shared and communicated). The elucidation of the patients' unconscious attitudes to their symptoms, as well as to themselves, to others, and to cure, is of great significance.

It is apparent that one can use such a small group for intensive analytical treatment. The indispensable precondition for this remains the analytic attitude of the therapist, and his capacity to make the patients active participants in their own healing process. The group-analytic situation is therefore in essence a transference situation.

The phenomenon of transference is of fundamental importance for all psychotherapy. In the strict and correct sense it describes an unconscious process by which the analyst becomes the representative of properties with which the parents, siblings and other significant figures were credited in early childhood. This is often expressed in symbolic ways.

We may here recall the two other essential conditions which make therapy possible, namely, that transference is a compulsive repetition of the most relevant and unresolved conflict situations, and that we would not be concerned if these were not still active at the time in the current life of the individual. A feature of the group situation is to put emphasis on

this immediate present. The importance of the 'here and now' was early recognized and expressed by me.* I was then, in the absence of any other observations, of the opinion that the individual transference neurosis could not be analysed in the group situation. In the light of 20 years' experience I must withdraw this statement. True transference neuroses of the individual can clearly be recognized in the group and therefore also analysed. It is true of course that this transference neurosis does not develop in the same pure style as in individual psychoanalysis, and that it cannot be analysed and worked through in the same detail. Whether this is due to the group situation or to the fact that I am referring to weekly sessions remains to be seen. It is also true that the transference neurosis develops in a different way in view of its multipersonal distribution.

As the analysis of the transference situation and the transference neurosis forms a central part of all psychoanalytic treatment, the usage has developed in recent years to call all reactions from the analysand to the analyst transference. Equally all human feelings in the psychoanalyst in relation to the analysand are frequently designated as counter-transference. This is too general and therefore confusing. One can convince oneself of this particularly well in group analysis, where deep 'true blue' transferences which emerge compulsively and have nearly delusional character, contrast sharply with the more spontaneous reactions to actual stimulations and persons. Naturally all human relationships have at least potentially elements of transference in them. However, it is right that the analyst should understand and interpret reactions in the therapeutic situation in the spirit of the transference situation, that he does not respond to them in his own real person, whether they be friendly or hostile, loving or hating, idealizing or denigrating. This is a fundamental and elementary feature of the analytic attitude; everything

* Foulkes, S. H. Memorandum on group psychotherapy. AMD 11 B.M. 33/02/2, July 1945.

that happens, without exception, is only there to be analysed.

Thanks to his training, and to his particular position in the group, it is for the therapist to represent the analytic attitude. All other members are allowed and even encouraged to react spontaneously exactly as they feel. As a consequence one is no longer dealing with patients, or cases which have a special diagnostic label, but with human beings who talk to one another about their affairs, their everyday life, their plans, their fears, their apprehensions, their worries, their pleasures, their guilt feelings, their suffering and their faith. They learn much about themselves and others which they did not know before. They act upon one another, and get to know themselves and others more frankly and more truly than ever before. Increasing understanding brings with it increasing tolerance, and the possibility of a freer development of the individual. I would like to underline this. Nothing is further from the truth than the idea that such a therapy has to do with conformity or with toeing the line. Even whether something is considered normal or not is, in my own approach, not a question of values (quite apart from the fact that it is for the group to make up its mind about this). Group analysis has not as its aim adjustment and socialization. It wishes to help human beings to find themselves and to live their own lives as well as they may be able to do. Moreover, they should do so without being inhibited, limited or disturbed by unnecessary difficulties or even, as happens only too often, by tendencies to do harm to themselves. The group analyst is no longer dependent on introspective self-observations on the part of his patients, nor need he wait until such observations are reported to him by other observers. He can himself observe the changing behaviour and reactions of his patients and make them the object for immediate analytic investigation. It is this fact of repetition under the conditions of the therapeutic situation (the 'T' situation) which gives particular value and significance to this analytical revision. The analytic thera-

peutic character of the situation stems, as we have said, from the analytic attitude of the conductor.

Such an analytic therapeutic attitude is in truth an inner disposition. It has to be genuine and cannot be faked or adopted. It rests in the first place in the personality of the therapist as it has developed according to his own natural bent and experiences. The capacity of the therapist to observe what happens in the patient's mind, to comprehend it, rests on his own empathy. He can never emerge untouched as he goes through this process with his patients. At the same time he must be free enough from personal problems not to be drawn into the emotional whirlpools of his patient. If occasionally this should threaten him, we can expect that he would take heed of fine and early signals, and take counter-measures. This is, by the way, necessary in the interests of his own mental hygiene; here lies the value of the therapist's own analysis and group analysis. These are problems of counter-transference. Its influence on the therapeutic group, quite particularly from unconscious sources, is hard to overestimate. We have been studying this over a number of years at the Maudsley Hospital, at a special seminar where we follow these problems on clinical material, in connexion with the training of psychotherapists. Here are some examples which show how the parts which patients play in a group, amongst them quite a number of typical roles, are not only conditioned by the patients' own dispositions, by their own relationships with one another and the therapist, but are also the result of unconscious projections, expectations and provocations on the part of the therapist. The examples are taken from supervision and are necessarily condensed.

(1) The therapist is conscious of difficulties he has with Mr S. He calls him his 'pseudo assistant conductor', who always monopolises the group and lectures to its members. He ineptly provoked talk on sexual matters and made an exhibition of himself in the group. At the same time denial in S was very strong.

The therapist wanted at times to remove S from the group. It turned out that S was in fact the *bête noire*, the shadow of the therapist, and when this was uncovered in supervision, a complete change occurred in the group. An independent observer remarked that the group now worked for the first time 'productively as a group'.

There are a number of such examples in which a member of the group, or the whole group, expresses an unconscious aspect of the conductor. In conventional language, this is an expression of counter-transference, but here, as always, we find that both conductor and his counterpart are influenced by a constellation in the group. At the same time this is an example of a *personification*, a patient representing an unconscious part of the therapist.

(2) A Mr N in Dr A's group was also the conductor's bad object and also referred to as 'assistant conductor'. This patient was blamed for being inconsistent and always looking for a bone of contention. The observer in this group reported that Mr N copied and imitated the therapist and that it looked as if the therapist hated a part of himself in N.

(3) In another case the therapist was very conscious of his irritation with the group, which consisted of five sexual deviants and psychopathic personalities. What disturbed him was their passivity. He recognized disliking one patient quite particularly, a paranoid psychopath who wanted to change into a woman. 'He is aggressive, really passive underneath, a psychopath, he annoys me', said the therapist, and added, 'I think what I hate in him is really the same reaction as my own.' On one occasion, when the group discussed the conductor for the first time, this same patient, unlike the others, said that the group would be better without the doctor (this patient had wanted his parents to die). Here the therapist was quite aware that the whole group, and in particular one individual, reflected a hated aspect of himself, a result of a conflict between aggressiveness and passivity. He saw less clearly that his reaction had been particularly

provoked by a demandingness on the part of the group to be given something magical which he could not provide. This is an example of an unconscious identification on the basis of a common dissatisfaction. Other group processes involved are '*resonance*' on the same oral basis, *dramatization* by splitting into aggressiveness and receptiveness. It also demonstrates the mechanism of '*polarization*', in this case between the therapist and the group on the one hand, and one particular patient on the other.

(4) The demand for infantile satisfaction, for some magical object (sometimes clearly phallic), is a frequently recurring theme. In another group there was reason to think that the therapist was struggling with this same problem, which he, however, experienced in a reversed fashion through the demandingness of his group. He presented this in the guise of technical difficulties over which he did not get sufficiently effective help and advice. One of the questions this therapist asked was how he could deal with X, a member of his group who continually attacked him. He, X, made D, another member and a newcomer to the group, quite ill with his attacks. X exerted a considerable influence on a patient P, but showed also a strong need to be controlled by him. P stood for X's wife. The therapist reported further that in this relationship, marked jealousy played a part, corresponding to an underlying homosexual problem. In the same group the therapist was struck by three different patients showing problems in connexion with identification with their sisters. He was also aware that tendencies to feminine identification in connexion with a sister were a problem for him at that time.

This example again shows the strong unconscious interaction between the therapist's and the group's problems. It also shows that these events belong to a shared context, current in the group, and are manifested at the same time in different constellations.

Other short examples of this mechanism, called '*multiple representation*' are the following.

In Dr W's group a number of apparently unconnected incidents seemed to be due to current tensions in the group. Some members were absent, one injured his knee, another had bronchitis. In another group three (out of four) women became pregnant within one year. In yet another group, led by the same conductor, almost everyone moved house.

In a further group, events were better understood. The manifest theme which occupied the group's mind at the time was jealousy and competition in married life, and guilt about spouses. This was at the same time expressed by a striking interaction of symptoms and by moves (changes in the choice of chairs) in the group. Outside, one patient practised promiscuity, another passed on his own symptoms to his wife, and another's husband felt obliged to seek treatment.

Apart from the element of acting out and the springing into action of the network, this is an interesting illustration of variations on a theme being represented in multiple interacting media. In yet another group such multiple representation was expressed by the simultaneous emergence of a multitude of triangular patterns. In fact no fewer than five group members were involved in clearly Oedipal problematic triangular situations, and it was interesting to observe the return of these excursions into the transference situation at a later stage.

The patient in such a group becomes for the first time really conscious of his own behaviour and able to modify it, to unlearn and to learn afresh. To experience himself repeatedly in a new and changed role and manner becomes an experience of consequence for him; still more so as the counter-reaction on the part of the group will also change. The overcoming of infantile fixations and dependence and the development of a more mature attitude thus become possible, together with real insight. Dependence on the therapist, who represents authority as conceived by the infant, is to a large extent replaced in the group by the more realistic dependence upon the group. As we know, the final solution of this dependence in

individual therapy and even in psychoanalysis is a difficult problem. In group treatment the step towards society and the community during and after successful treatment is a much more natural one.

Each individual patient, if we put him into the centre of our consideration, can be caught in the attempt to repeat his own neurosis and its genesis and to force his neurotic pattern on the others. Yet at the same time these individuals between them, in their complex interactional network, produce a new dynamic field.

This existence of group psychodynamics is now increasingly recognized, but too often looked upon as something totally different from, and even antagonistic to, individual dynamics. It is said, for example, that these group- or socio-dynamics are of interest to the sociologist but that their bearing on psychotherapy is non-existent or minimal; they are external, whereas psychology is concerned with psychodynamics, i.e. intrapsychic phenomena. In my view this juxtaposition of the individual and the group rests on a misunderstanding and leads to unending and insoluble pseudo-problems.

We are concerned first of all with psychodynamics. These are rarely, if ever, confined within the boundaries of the individual but regularly include a number of interconnected persons. They are transpersonal manifestations. From the beginning my endeavour has been to do justice to the essential unity of psychodynamics, whether they are studied or observed in a one-, two- or multipersonal situation. I have attempted to base operational concepts on the phenomena and processes which can be observed, and which express this identity of psychodynamics. These can best be seen within a group just because of their transgression of individual boundaries. The therapist in our group needs in any case to focus on the group context for his intervention and interpretation, otherwise he would be lost in the bewildering multitude, simultaneously on different levels, of reactions and possible interpretations. Taking these transpersonal

processes as a guide, he is also prevented from being drawn into the quagmire of an individual versus group controversy.

It seems very hard to accept the concept of a psychic network inside which frontiers and boundaries of individual egos are continuously fluctuating, now suspended, now re-established. On this level the group is an intrapsychic one; configurations are dramatizations of inner unconscious processes; the others are personifications of split-off parts of the own ego. On a more everyday level, this same group is of course composed of definite individuals, who act upon one another or who revive old family constellations with one another in transference. It seems not easy to orient oneself here. The group analyst should be able to enter into all these wavelengths, if not at the same moment, at least in quick oscillation. It is only in this way that he can really follow the group, understand what is happening, and judge whether his intervention is necessary or possible.

The group-analytic orientation is mainly a matter for the analyst, and is personified in him. I will therefore sum up some of the principles from his point of view. In the first place he creates and maintains the group-analytic situation as I have described it. He leaves the choice of themes to the group, gives

full reign and validity to phantasy, including his own person. In this respect he is completely receptive; he follows the patient and his attitude is that of the psychoanalyst. In the interpretation and analytic elucidation of resistances and defensive mechanisms he is far more active. He promotes spontaneous communication and insight through his comments, confrontations and interpretations, and through this exerts a catalytic influence. In the transference he must be prepared to tolerate a considerable measure of dependence upon him, especially in early stages. But, step by step, he weans the group so that dependence becomes replaced by greater independence of thought and action. Thus the need to be loved and to be led, and the belief in authority, is gradually replaced by the authority of the group which after all reflects the values which are 'normal' in the particular culture. But all valuations are subject to analysis, regardless of whether they are considered normal or not.

The therapist has a creative task. In a sense he is continually active, and at times markedly so. That we stress the group as a whole for the orientation of the therapist must not confuse us. This form of psychotherapy is, in the last resort, alone in the service of the individual human being and the freer development of his individuality.

Disturbances of perception and consciousness in schizophrenic states

BY JAMES DAVIE AND THOMAS FREEMAN*

This paper is devoted to an account of the disturbances which affect perception and attention in cases of schizophrenia. At the same time it is concerned with the state of consciousness which may be associated or causally related to these upsets. The clinical material has been gathered from four patients who have been undergoing what can be described as a psychotherapeutically orientated investigation. The first patient is a young woman of 21, a nurse by profession, who has been in hospital for 2½ years except for one short interval prior to the beginning of psychotherapy. Her condition would be most suitably diagnosed as a moderately severe case of hebephrenia. The second patient is aged 26. He has been ill for 6 years suffering from a catatonic illness, which is also characterized by a pronounced disorder of thought. The remaining two patients—both men—have been diagnosed as paranoid schizophrenia. One had been a schoolmaster, he is 32 years old and has been in hospital for nearly 3 years. The fourth patient, a student of 21, was ill for about 6 months. He was in hospital for 4 months during which he was the subject of this investigation.

THEORETICAL CONSIDERATIONS

As our inquiry is principally concerned with the disturbances which affect perception, attention and consciousness in schizophrenic states we must begin our presentation with an account of the manner in which these mental functions develop and operate in the healthy individual. If we turn to Freud's (1900) formulations on the mental apparatus we can

see the role which he assigned to perception in the achieving of purposive thinking, attention and reflective awareness. Freud (1900) described consciousness as a sense organ whose function was the perception of what he called 'psychical qualities'—by this term he referred to the range of differentiated sensations which are an intrinsic part of conscious experience. Originally thought processes are in themselves without such qualities apart from those of the pleasure pain series which are in turn the result of the accumulation or discharge of drive cathexes. The attainment of psychic quality by preconscious processes occurs when connexions are established with verbal and perceptual memories. In this way preconscious processes become objects of perception as a consequence of the remnants of sensation inherent in the memory traces. Consciousness originally adapted solely for the reception of external and bodily perceptions now becomes a sense organ for the perception of thought processes also.

The 'sense organ'—consciousness—is in receipt of stimuli from the environment and from the interior of the apparatus. As Freud puts it (1900): 'Now therefore there are, as it were, two sensory surfaces, one directed towards perception and the other towards the preconscious thought processes'. Anticipating the results of recent research in the psychological laboratory he proposed that the stimuli which enter the mental apparatus by way of the sense organs are not delivered directly into consciousness but are subjected to what he described as a 'fresh revision' before reaching consciousness. This hypothesis has found verification in the researches of George Klein (1959) and Fisher (1956) who have demonstrated experimentally that there are unconscious pre-stages of perception during which the

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memory traces of visual stimuli are subjected to a series of transformation before becoming conscious as fully developed visual percepts or images. With regard to internal stimulation some modification is effected in the sensations of the pleasure—unpleasure series before they reach consciousness.

Freud recognized that the purposeful awareness of percepts, thoughts and images is not a passive process. These mental contents do not find their way automatically into consciousness after having completed their development unconsciously. In this they stand in contrast to certain pathological phenomena which will be referred to later. A further process takes place which is initiated by the organ of consciousness. This consists of a new distribution of cathectic energy. Additional cathexes are invested in those mental contents which are destined to become a part of conscious experience. Without this hypercathexis admission to consciousness would not take place. As in the case of perception the act of becoming conscious is an active process on the part of an ego function which itself must be cathected before it can fulfill its role. For the purposes of the present discussion the role of counter cathexes in determining the content of consciousness is deliberately omitted.

In the earliest phase of development the contents of consciousness are regulated by the pleasure pain principle. The build up of libidinal cathexes, due to frustration, leads to the hallucinatory revival of memories of past satisfaction or as Rapaport (1951) puts it the presence of undischarged cathexes leads to the first form of cognition. As long as mental activity is governed by the pleasure principle it remains a crude instrument for environmental adaptation—being only concerned with the release of accumulated instinctual cathexes. Freud (1900) states '... in order to make more delicately adjusted performances possible, it later became necessary to make the course of ideas less dependent upon the presence or absence of unpleasure'.

The growth of consciousness is also characterized by the development of a restriction

upon the influx of external sensory stimulation into awareness. A concomitant differentiation of sensory modalities takes place which could be thought of as similar to the development of 'psychic qualities' (Freud, 1900). These processes allow thinking to proceed without being unduly influenced by the build-up of pleasure pain sensations derived, in this instance, from external stimulation. Here again Freud's insight has been confirmed by the investigations of the experimental psychologists mentioned above.

The relationship of percepts—and this includes thought content—to consciousness is best understood if we follow Freud's first assumption that the consciousness is a cathexis or attention dispensing organization. The awareness of percepts in consciousness—their form and quality—will be determined by the distribution of these attention cathexes. We can look upon consciousness as Rapaport (1951) does as '... characterized by having contents and being capable of awareness of having them. Furthermore, it is capable of becoming aware of itself'. This capacity for self-awareness results from a specific distribution of attention cathexes. It is an aspect of the normal waking state of consciousness with which is associated the secondary process form of thought organization.

Finally, we would like to recall that Freud derived the origins of the ego from somatic sources—'The ego is first and foremost a body ego...' (Freud, 1923). This statement points to the conclusion that the integrity of the idea of self cannot be separated from an undisturbed perception of bodily sensations. Disturbances of awareness and disturbances of bodily perception frequently go hand in hand as our clinical examples will show.

CLINICAL MATERIAL

The following clinical examples illustrate the disturbances of perception and consciousness which may occur in schizophrenic states and which are associated with defective attention and concentration. It is our intention to

describe a few of these phenomena and then examine them in their relationship to mental conflict. For purposes of presentation we have divided the clinical data into a number of different categories.

Dedifferentiation of perceptual experience

I

The phenomena which will be described under this heading consists of perceptual disturbances involving the visual and auditory senses. In three of the four cases there was a falsification of the visual perceptual response. Nurses, doctors and attendants were mistaken for those who had an important affective significance for the patient. The young nurse thought that one of her fellow female patients was a man she had been in love with. These patients had lost, to varying degrees, the capacity for perceptual constancy. Normally objects, both animate and inanimate, have a fixed appearance which is relatively independent of position or of emotional fluctuations. Adjustment to the environment is dependent upon this factor of constancy and upon the discrete and differentiated nature of perceptual responses. Environmental adaptation also demands that visual percepts do not evoke overwhelming instinctual need which would automatically lead to action. This would follow the laws of the primary process. The nurse commented on the fact that her doctor's face had changed in shape but when the doctor moved or she moved she could perceive normally. On another occasion by moving she could abolish a visual hallucination which appeared alongside the doctor's face. She employed the principle of parallax to restore depth perception and reinforce the supremacy of the reality principle. A young male patient who has been reported on previously (Chapman, Freeman & McGhie, 1959) found that he had to use an opposite mechanism to achieve the same result. He reported that when an object in his visual field moved he had to move also in order to preserve perceptual constancy.

A series of disturbing visual percepts were reported by the pharmacist. He began these communications by saying that he had lost his eyes into a small prayerbook. This anxiety accounted for his constantly looking at his eyes in the mirror and palpating them with his fingers. A few days later he pointed to the prayerbook which had a brightly painted cover depicting the Virgin Mary and said that at the previous interview he had found it necessary to touch the picture with his fingers to see it. As he spoke he made a sweeping movement with his fingers. This communication was followed some days later by a complaint about the food in his ward. He said that the food was congested on the plates. When he was asked what he meant by this he replied that the plates had a peculiar shape and that they were somehow merged—going off was his expression—to the food. That merging was what he meant was confirmed by his next statement, 'At times I feel as though I am eating the plate as well as the food'.

The nurse showed a different kind of perceptual upset. She reported that when she felt she saw. By this she referred to the appearance of a visual hallucination of one of a number of young men with whom she had flirted on numerous occasions prior to the onset of her illness. In this case seeing and feeling were no longer differentiated. When she was possessed by intense sexual feeling stimulated by some love object—the transference relationship provided one of these situations—the only way in which she could extinguish these feelings was by looking at herself in the mirror. This phenomenon could be described as a form of negative hallucination. A similar instance has been reported by Eissler (1953).

II

We have previously reported on a patient (Chapman, *et al.* 1959) in whom there was a loss of differentiation between the auditory and visual senses. He said that 'a movement in front of my eyes is like hearing a sound in my ears'. This loss of differentiation extended to

other senses also in the case of the nurse. She announced at different times that she was having intercourse with a voice, and later with a gramophone record. The voice or the music was actually fused with genital sensations.

We have observed a further variety of dedifferentiation affecting auditory perception. When the pharmacist was asked about some peculiar sensations in his head he replied that any discussion about this would hurt his head all the more. In this instance we were given a glimpse of a level of mental organization in which percepts have a concrete component. A transitional state between concrete percept and concrete thought is revealed in the same patient who said on being told that his next appointment would be at 2 o'clock—'I'll hold the two'. A similar transitional state could again be inferred when he said that another patient in the hospital had got smaller to respect her father. This concretization of an auditory percept was observed also in the schoolmaster who became very aggressive whenever his name was mentioned. He felt as if something had been taken from him. The further ramifications of this phenomenon will be described later.

III

The phenomena described thus far indicate that in the cases of the pharmacist and the nurse there was a dedifferentiation of auditory and visual perception. We appear to be dealing with something akin to the formal category of regression which Freud (1900) described in *The Interpretation of Dreams*. In the psychotherapeutic setting we are offered the opportunity of witnessing the presence, or even the appearance and occasionally the disappearance of these phenomena. Although the emergence of some of this data could be seen as a response to feelings awakened by the transference—as distinct from a transference neurosis—this was not a uniform occurrence in every case. The impact of the transference in the nurse led to the appearance of visual perceptual abnormalities—the phenomenon described as akin to negative hallucination,

and the loss of both clarity and constancy of perception are cases in point. She had also reported that on coming to the consulting room she thought her doctor was playing the gramophone. When asked about this in terms of her previous statement about having intercourse with a gramophone record she replied that she sometimes had the feeling that her doctor was the gramophone. We have noted how she was able to achieve a constancy of perception of her doctor by moving her head. This awareness was followed immediately by a feeling of rage. We may ask whether we are dealing in this instance with a simple association or with a causal relationship. Was the loss of perceptual differentiation a defence against transference feelings or not?

We have described other perceptual responses which do not seem to be causally related to transference affects apart from the fact that the patient reveals such data under the influence of a positive transference. In the case of the patient who complained of the plates it was only after three to four months of continuous psychotherapeutic contact that he revealed this and other information. Nevertheless, at no time could these dedifferentiated responses be unequivocally related to affective factors.

Disturbances of bodily perception

I

Although abnormalities of bodily perception in schizophrenia have been frequently recorded we felt it worth while to describe a few observations of this kind because of their association with the disturbed perception of the body boundaries. This was clearly seen in the student who at the height of his illness showed that he was unable to separate himself from the objects in his environment. For example, he would take 'get well' cards from other patients' lockers, get into other patients' beds and attempt to wear other patients' clothes. This loss of differentiation was to be observed in the transference when he believed that the doctor had his thoughts. Later this

was transformed into the conviction that he was being hypnotized and influenced by a system of hidden microphones from the consulting room to wherever he might happen to be. This apparatus allowed the doctor to know and influence his thoughts. It is worthy of note that the precipitation of the illness was the result of castration fear. This anxiety situation was followed by his first psychotic symptom—namely, the belief that his penis was irrevocably damaged and that he was changing into a woman. The more detailed study in the treatment situation made it clear that the psychotic process of dedifferentiation of the body boundary found a mental representation through the homosexual conflict of the prepsychotic phase.

The second case to which we would like to refer is of interest because it presents the problem of loss of identity from another point of view. The patient in question is the 32-year-old schoolmaster who became aggressive whenever he suspected his name was being mentioned. He said that when other men used his name this was equivalent to abusing him—this meant they wanted to take his manliness away from him. He soon felt the same about his doctor. Fortunately he was able to explain that on such occasions he felt that the doctor possessed his thoughts and he even felt that their bodies were merging. In the following session he reported that he had assaulted two patients and much as he regretted it the merging feeling had been so upsetting that physical violence was the only means of preserving his individuality.

II

In both these patients normal awareness of the body was upset and there was a disturbance of its boundary. The relationship of the homosexual conflict in both cases to these perceptual disturbances is a matter of considerable interest. In the case of the schoolmaster it is clear that the current stimulus for the merging process is provided by unconscious homosexual wishes. Unlike the student this man was unaware of a homosexual problem yet the

content of his psychosis was coloured by this specific conflict also.

Although inspection of the contemporary situation both in the treatment and in the ward reveals the importance of the homosexual conflict it is important to point out that the precipitant of both illnesses was castration fear which in turn provoked a regression to homosexuality.

Disturbances of attention and concentration

I

During our psychotherapeutic work we have had many opportunities to observe the disturbances of attention and concentration which are so commonplace in schizophrenic states. We decided to include this material in our collection of observations because it points to the altered state of consciousness which occurs in the disease. We would like to describe two episodes which illustrate some aspects of this defect of attention. The pharmacist told his doctor that it was his birthday the following week. To mark the occasion he was presented with a small box of chocolates. He inspected the box from numerous angles but during the entire session made no mention of the gift. His miserable expression provoked the comment that he did not look very happy. His immediate response was that he had obtained first place in practical chemistry at the technical college. He then said 'Happy Anderson'. Questioning revealed that this was the name of his chemistry teacher at the college. The patient then examined a pulse and temperature chart which he had looked at the day before and had used to orientate himself with regard to the day and date. He read out the patient's name on the chart and followed this by some irrelevant comments about the name of a ship's captain. He ended up by asking if the doctor knew a man called Duncan. It was of interest that the box of chocolates which he had examined so intently and yet had in a sense ignored was manufactured by Duncan's Ltd. At the end of the session he walked to the door and said 'Thank you for

the chocolates'. This was the only rational sentence he uttered during the session.

The second example took place just before the beginning of a session. As the doctor came into the ward he happened to say to an attendant that it was a very wet day. This was said within the patient's hearing. Both the patient and doctor then walked to the consulting room. When they reached the door the patient excused himself—returned to where he had been standing and then walked back. When he was asked why he had to retrace his steps he said that his feet were damp. In fact, he had not been out of the ward all day.

In these two examples we can observe the patient's inability to attend to what is said to him. His capacity for attention is so limited that he replies with what appears to be wholly irrelevant responses. At times he seemed to be aware of his difficulty because there were occasions when he would ask for a sentence to be repeated and then he would mutter it under his breath as if trying to get it fixed in his mind. Even then he would not be able to respond to the communication.

II

The same patient gave us the opportunity to observe his difficulty in concentrating upon reality adapted thoughts and pursuing them to completion. For example, he recalled that at a previous session he had told the doctor that his mouth (that is, the doctor's) would have to be changed. He then stopped speaking and could not be induced to begin again. His eyes were fixed on a cupboard. Another day he stood up, looked in the mirror and began to comb his hair. He apologised saying 'I hope you don't mind me combing my hair'. He followed this by perfectly rational remarks about his weight and his laundry. However, this rational train of thought was interrupted and he went on to say 'You remember I was telling you about my Adam's Apple the other day and how I made a small cut on it?'. This was followed by some remarks to the effect that he was not really a man and that he was not

really a boy and that he had written a 'masterpiece of the English language'. He often gave the impression that he had something to communicate but he could not get beyond the first few words. Frequently he would interject—'What was I going to say?'. On one occasion he succeeded in pursuing a line of thought for some distance. He said, 'I have something to report to you doctor' and then he was silent. He followed this by saying 'Do you know you are...' and then he was silent again. When he was asked what he wanted to say he looked angry and ignored the question. When asked again he said, 'You are stupid—you don't pay attention to what I say to you'. When he was asked what he had said he completely lost his temper and shouted 'I told the man in the ward to bugger off—I told him to bugger off and stop talking such nonsense'. At this point he was quite livid. When he was asked what he was angry about he replied 'Why I'm angry is not good poetry. I am... (he paused and said)... a fine poet—no, not a fine poet, a fine poet is a fine public schoolboy'.

DISCUSSION

I

The clinical data presented above and similar material reported in the literature point to the possibility that in some forms of schizophrenic illness the signs and symptoms may be related to disturbances of perception. Such a possibility raises the question of how perceptual upsets could lead to the clinical manifestations—particularly the disorder of thought. There is also the problem of the relationship of perceptual dysfunction to mental conflicts. How far do such conflicts initiate, perpetuate or aggravate the perceptual abnormality?

Some headway may be made if we return once again to Freud's theory of consciousness which he outlined in *The Interpretation of Dreams* (1900). The growth of consciousness is associated first with the development and differentiation of sensation, i.e. the development of the 'qualities of sense' (Freud, 1911); second, with the restriction of sensory input

which results from 'the processes of sensory regulation' (Freud, 1900); and third with the relegation of the pleasure pain principle to a secondary role as a determinant of the contents of consciousness. The clinical phenomena reveal quite unequivocally that there is a failure of one or more of these three processes in the categories of schizophrenia reported in this paper.

We have seen how some patients no longer differentiate sensations and in the case of the pharmacist we observed an inability to preserve thought processes from extraneous stimuli. This difficulty has been encountered quite often in patients whose ego is in a state of deterioration. We note too that both the schoolmaster and the student became aware of an intrusion into consciousness of sensations which heralded an impending dissolution of the boundary between the self and the world of objects. The pharmacist also complained of abnormal changes affecting his body and his report that his eyes had fallen into a book suggested that he could not always clearly delimit his bodily boundaries. With regard to the contents of consciousness the young nurse demonstrated how her thinking was dominated at times by the pleasure principle. When she hallucinated the memory of gratifying experiences she was unable to control the direction of her thoughts. She had to smoke or suck sweets to abolish the hallucination. In her case we are presented with a series of phenomena which makes the following quotation from Freud all the more instructive and meaningful—'Thought processes are in themselves without quality, except for the pleasurable and unpleasurable excitations which accompany them, and which in view of their disturbing effect on thinking, must be kept within bounds' (Freud, 1900). Our patient had lost her capacity, on these occasions, for reality adapted thinking along with a failure in sensory differentiation—consciousness was no longer characterized by 'qualities of sense' (Freud, 1911).

We must now consider how the disorder of thought which is characteristic of schizo-

phrenia and which was so pronounced in our pharmacist can be interpreted as the outcome of a perceptual dysfunction. We have learned from Freud that conscious thinking becomes possible whenever thoughts offer themselves to consciousness as objects of perception. According to Freud's theory (1900) purposive thinking is dependent upon a connexion being established between preconscious processes and verbal memories. Once this occurs thought processes can in Freud's words (1900) '... draw the attention of consciousness to them and (to) endow the processes of thinking with a new mobile cathexis from consciousness'.

Thinking may be considered, therefore, to be dependent upon an active perceptual process initiated by consciousness. It is, at the moment, immaterial whether or not we conceive of consciousness in structural terms or as a functional system. According to the theory outlined above consciousness operates with regard to thought processes as it does in regard to external perception. A special aspect of consciousness—attention—undertakes the double task of directed thinking and perceiving. The clinical illustrations indicate that under certain conditions the patient is unable to maintain a directed flow of thought. It is, indeed, as if his verbal memories have lost their hypercathexis and are thus no longer in a state adequate for perception by consciousness. However, it is probably not simply a matter of the loss of hypercathexis. If the application of Freud's theory to the clinical data is followed through we must allow for the possibility that in schizophrenic states consciousness has other deficiencies also.

The failure to perceive thoughts for the purposes of thinking must be attributed to the loss of what Freud describes as the 'qualities of sense' (differentiation of sensations) because according to his theory it is the link between these qualities derived from memory traces and preconscious processes which is one of the preconditions for the development of consciousness as we know it in the healthy adult. Can we conceive of a pathological process interfering with this connexion between the

preconscious thought processes and the verbal memories? We know that Freud (1915) proposed that in schizophrenia the word representation is torn away from the concrete image of the object itself. Once this has occurred words no longer have their correct meaning.

These theoretical considerations may help to clarify some of the confusion which permeates the problem of thought disorder. In the case of the pharmacist we were presented with two different varieties of this phenomenon. On some occasions he was unable to sustain his flow of thoughts for more than a few seconds. On other occasions he could do so for long periods. Sometimes the content was intelligible sometimes it was not. These phenomena may result from the fact that a defective perception of thoughts and a breakdown of the representational function—to use Hartmann's term (1953)—need not coincide. It may be that the former process will operate normally but the latter process will be under the pathological influence. This would lead to the expression of thoughts which would be incomprehensible to the observer. On the other hand if perception is defective and the representational function intact then the communication, even if intelligible, will not be sustained beyond a few words. Before leaving this difficult subject of thought disorder we must remember that the ability to attend is also dependent upon a restriction of sensory input into consciousness. The observation of patients—particularly the young pharmacist—reveals the presence of both a failure of this restriction and a simultaneous loss of the ability to maintain perception of thoughts at an intensity sufficient for awareness.

We have presented our clinical data and the above-mentioned theoretical ideas because we are in the process of searching for a number of criteria which might enable us to assess the variations in the state of consciousness which occur in schizophrenic syndromes. However, our account would be seriously deficient if we were to omit Rapaport's (1951) contribution to this subject. He has pointed out that such

phenomena as hallucinations, delusions and other contents are not dependent upon a hypercathectic process for their entry into consciousness. Their appearance is automatic and independent of deliberation. They are not the result of purposive thinking and they appear to be under the influence of the pleasure principle. The hallucinations of the nurse and the intrusion of random auditory percepts into the stream of thought of deteriorated patients are characteristic of this state.

It would appear then that if we wish to make an assessment of the state of consciousness of a schizophrenic patient at any given moment in time we must pay attention to a number of factors. First, we must note the presence or absence of dedifferentiation of sensation. Secondly, we must consider whether the patient is capable of a hypercathexis of thought—whether he can sustain his communication. Thirdly, we must look at the representational function. Fourthly, we must determine whether he is able to isolate his thought processes from the influence of other percepts—verbal, external, or bodily. Fifthly, we must assess the degree of his awareness of his bodily boundaries, and sixthly we must pay attention to those contents of consciousness which appear to be less associated with the hypercathectic process than with the pleasure principle.

II

It can hardly have escaped notice that there was no reference to mental conflict in the above-mentioned list. We would now like to rectify this omission by discussing the influence which this factor may have upon the various mental processes which appear to be of significance in determining a state of consciousness. We have seen how unconscious mental conflict can initiate a series of events which leads to the appearance of psychotic symptoms. In both the schoolmaster and the student these symptoms consisted of a disturbed perception of the body. We have also seen in the case of the pharmacist that the expression of hate was associated with a restoration of the normal

capacity for thinking and communicating. These observations indicate that the transformation of a normal into a pathological state must be associated with an underlying affective disturbance. In the former instances the affective disturbance was clearly linked with unconscious conflict but in the latter such a conflict was not in evidence.

We have presented a number of clinical illustrations which indicate that the transference initiates a series of processes which lead to the appearance of dedifferentiated percepts of both the senses and of the body. This was so in the cases of the nurse, the schoolmaster and the student. The situation was somewhat different with the pharmacist. His ego was much more deteriorated and his communications difficult to understand. There were times when he was able to reflect on the perception of his body and then he could talk about his unpleasant experiences—for example, that part of his face had fallen off. None of his communications, in contrast to the other three patients, involved his doctor. He was very preoccupied with himself and the intensity of his pathological narcissism was revealed one day when he was contradicted about the time. He flew into a rage and screamed 'I am the time'. Although the transference was weak when compared with the other patients he was mostly pleased with his therapeutic relationship.

Perusal of this patient's case history revealed that immediately prior to his breakdown he had become interested in a girl. We may assume that an unconscious sexual conflict precipitated his illness. However, the deterioration of his thinking and ego functions has made it well nigh impossible to discern any of these conflicts. It is likely that in the chronic state a specific conflict is no longer the stimulus for the appearance of a specific symptom. When this man complained that his eyes had fallen into the prayerbook during a therapeutic session, it was impossible to connect this either with the transference, such as it was, or the events of the day.

The time is surely ripe for a detailed study of those mental processes which seem to be implicated in the production of states of consciousness which characterize schizophrenic syndromes. We cannot be satisfied with a purely descriptive account of these processes although Freud's theory of consciousness gives us a plan for the classification of this data. We must investigate the dynamic and economic aspects of these phenomena—their relationship to conflict and to the pleasure pain principle.

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Psycho-social factors in the aetiology of disturbed behaviour

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The structural properties of social organizations in which men live often appear to affect human behaviour directly. Thus social scientists rightly perceive that if the social organization of therapeutic institutions is ignored, treatment is likely to be less efficient. The present study is an attempt to differentiate some of the multiple determinants of disturbed behaviour among patients in institutions, with particular reference to adolescents. Specifically the relationship between sociological system stresses and interpersonal relationships will be considered, especially in outbreaks of delinquency of the gang type. A parallel between such behaviour in institutions and in society then becomes evident. Two types of institution will be considered: *custodial*, in which, whatever the overt goal, ideologically the staff tend to be authoritarian and disciplinarian, with a prime goal of having the institution run as peacefully as possible; and *therapeutic*, in which the rehabilitation of the individual is of prime concern.

One necessary factor in the successful treatment of disturbed adolescents with weak ego functions and poor impulse control is the provision of a flexible system of external controls by the staff and the patient community (Miller, 1957). Any patient should have the maximum amount of responsibility he can handle, but the staff and the whole institution should be prepared to act as an auxiliary supportive external ego for those individuals who cannot control their own actions. Without rigidity and according to the needs of the individual, the controls should be such that a patient can himself predict that there will be a helpful environmental response to his disturbed behaviour. This staff response may consist of the provision of additional contact of an interpretative or supportive nature; or of a relative increase in supervision or of a lessen-

ing of demands made upon the individual. If an institution fails to provide controls, or is too rigid and non-individualistic in their application, then patients (particularly adolescents) may isolate themselves from the staff, and develop their own group mores which are rigid, hierarchical and, in a highly disturbed group, often brutal.

In the usual adolescent struggle in our culture the need to be independent is often expressed as adolescent rebellion. Thus any system set up to treat disturbed adolescents should recognize this and allow safe areas wherein successful rebellion is possible. Society does this, as for example, in permitted rebellious behaviour associated, for example, with Hallowe'en and Guy Fawkes.

CHRONIC ANTISOCIAL BEHAVIOUR

Given an optimum therapeutic environment, a group of potentially disturbed patients can function in a well-integrated fashion; but under stress such a group shows its disintegrative behaviour in (often quite subtle) chronic anti-social withdrawal from the mores of the system. The system may develop chronic symptoms, which may be relatively unnoticed, and whose aetiology is often obscure.

In a hospital in the United States some patients attended hospital activities, which were scheduled for them with their doctors, on their own. This was officially defined as 'grounds privileges', the right of patients to come and go as they wished in the hospital and its environs, provided they attended their activities punctually and constructively. On occasions the patients unofficially defined 'grounds privileges', with some unconscious collusion by the therapists, as the right to attend any activities they liked, to arrive late or to miss them altogether.

If the system is functioning well these covert

symptoms are relatively insignificant. All hospitals seem also to develop typical patient group reactions to stress which are special to the institution. Some have episodes of incontinence, others clothes-tearing, others running away, others property destruction or alcoholism.

For example, in a children's hospital in England, the children would go on to the roof, which was dangerous, when they became rebellious. When this became no longer a possibility they used other devices.

Chronic institutional reactions occur much more frequently in custodial institutions in which the therapeutic goal has become obscure. In the individual and the group five main types of institutional reaction may occur (Miller, 1955).

(1) *A chronic paranoid response* in which the individual is constantly at war with his environment and feels that it is against him and means to harm him.

In an approved school in England it was not possible for a boy to talk freely to a staff member in sight but not sound of other boys. They would immediately assume that he was telling tales about them ('shopping them').

(2) *A depressive reaction.* For some individuals the impotent rage which is aroused by institutional demands for conformity, which is often quite unlike anything society normally expects, may be internalized. There tends to be a chronic change in the activity level of the patient, often his appearance is dilapidated and he shows an inadequate and inappropriate environmental response. In many prisons and large custodial mental institutions such a group of depressed withdrawn people is commonly seen. When a hospital becomes therapeutically orientated often members of this group may not appear to react positively, but on discharge the response may be dramatic.

A 54-year-old woman, hospitalized for many years in a State Hospital in the United States, appeared to be showing no overt reaction to the changes in a ward which was converted from a custodial to a therapeutic environment (Miller, 1954). She attended social groups, ward govern-

ment meetings and therapeutic activities only with much push from the staff and her depression appeared untouched. She was ultimately discharged to a nursing home run by a warm lively woman and within three months she had returned to her community, became an active leader of the local women's clubs and after five years was continuing to make an excellent adjustment.

(3) *A chronic catatonic response* which occurs mostly in those patients who are diagnosed as 'schizophrenic' who have previously used motor behaviour as a way of dealing with internal stress. There is a psychological and physical withdrawal with intermittent bursts of diffusely directed aggressive activity. The patients' verbalizations are normally incomprehensible, as if they disclaim responsibility for their own aggression and ensure that there can be no external consequences.

(4) *A psychopathic response* in which the individual is constantly manipulating the external environment to obtain gratification for himself. Often he is a staff favourite. Typically in prisons the 'psychopath' is a good prisoner who manages to engage in all the subterranean and prohibited activities of the institution. This is known to the staff but they rarely interfere because the patient gives no overt trouble.

(5) *A passive-neurotic response* in which the individual 'gives in' and willingly fulfils the infantilizing demands of the institution. He does only what is expected of him, no more and no less.

Except for catatonia all these responses may occur independently of the original diagnostic label given the patient, although are a function of the patient's personality organization. They may also be seen in staff who have worked for long periods in custodial institutions. These reactions may also be seen transiently in therapeutic institutions.

ACUTE ANTISOCIAL BEHAVIOUR

All institutions, custodial and therapeutic, tend to have episodes of acute disturbance in the patient group. In therapeutic institutions they tend to be moderately rare and confined.

A mass disturbance represents a therapeutic failure. These acute disturbances may be diffuse and unorganized, or they may be organized 'delinquent' outbreaks.

The present study will report on some of the important aetiological factors leading to acute disturbances among groups of patients, both diffuse and organized, in a therapeutic institution.

DIFFUSE ANTISOCIAL BEHAVIOUR

Group disturbances occur if the balance between patients' own internal controls and the external support they receive is disturbed. Thus any situation which produces a stress for a patient group without a concomitant increase in internal controls or external support is likely to lead to disruptive behaviour (Stanton & Schwartz, 1954).

If the stability of the staff is threatened by a shifting of role groups within the hospital or if it is faced with a sudden severe unpredictable stress and cannot provide support, disturbance is likely to occur. For example, it has been demonstrated that a mutual withdrawal of staff groups from each other and the patients, following a transition from a diagnostic to a psychodynamic treatment programme, may lead to a collective disturbance among a patient group, primarily because of communication breakdown (Caudill, 1957). When a stress starts with disturbance in the patient group, to which significant staff members react inadequately, the resultant stress on the system can lead to role withdrawal among the staff, staff withdrawal from patients, patient withdrawal from patients, and a resultant increase in the intensity of the disturbed behaviour (Miller, 1957).

Within the patient group diffuse antisocial behaviour can occur in the following situations:

(a) *Tasks arousing mutual hostility among the group*

If a patient is placed in a situation which threatens the impulse control of the group members, disturbances can occur. Typical of such a situation is a loosely structured highly competitive sport.

(b) *When the 'external ego' controls appear weak*

If an interpretation of disorganized patient behaviour cannot be used to control it, staff members have other possible control devices. If they are liked and admired by the patient then control may occur as part of the patient's identification with the staff, summed up by the phrase 'the patient first has to like you in order to be like you'. If this process occurs the ego-controlling comment of 'you don't need to do this', or the like, will help the patient to control aberrant behaviour. Should this fail or appear futile the positive superego approach of 'I do not want you to do this' may be necessary; only if this is valueless should 'you must not' be necessary. If the adolescent with a weak ego and an uncertain masculine identity feels that staff who are significant to him are successfully attacked by a member of his own peer group, then the staff figures become less admired and less satisfactory for identification. Thus if a new patient is successful in his early attempts at delinquent behaviour (often part of his attempt to gain status with his peer group) the whole group of patients is likely to become disturbed.

(c) *Peer group power struggles*

Struggles for power within a patient group hierarchy can also produce disturbed behaviour. If a patient group leader is highly identified with the aims of the institution, well-integrated group functioning is likely, particularly if he is the leader in all areas of group functioning. If there are several leaders for various group tasks, the departure of any one is not likely to lead to overt disruption, but with one leader only his departure may lead to upset, particularly if he maintains this role only with difficulty.

ORGANIZED COLLECTIVE DISTURBANCES

The step from a diffuse disturbance to organized delinquency of the gang type is highly significant both in terms of understanding this behaviour in the community and also in preventing its occurrence in institutions. The

following outbreak occurred in a hospital in the United States.

Six boys and four girls lived on one floor with a total capacity of fifty-eight patients. They shared living quarters with adult patients although they had a specially planned treatment programme. Patients were of both sexes and diagnostically mixed.

Five of the boys, who had been admitted to the hospital with histories of severe emotional disturbance and sociopathic symptoms, were a self-chosen group who did many things together. Four had been living for some time in foster homes in the community, either attending the local High School, the Day Hospital, or both. Their re-admission to the hospital had been precipitated by an increase in their destructive symptomatology.

The disturbance began with a diffuse patient reaction, as shown by a disinclination to go to bed at night and an increase in interpatient 'boot-leg psychotherapy'. Group paranoid behaviour appeared and patients would be seen whispering together, becoming quiet when staff approached. Because adolescent patients tend to externalize their problems more than adults, this behaviour was more apparent among them. The five adolescent boys, who were later involved in an organized collective disturbance, intermittently provoked the staff by refusing to go to bed on time, refusing to go to school or to their activities in hospital. They became sloppy in their dress and more overtly aggressive towards the staff and one another. They withdrew almost exclusively into one lounge area in the hospital during free social periods.

Five days prior to the overtly delinquent outbreak the group of five boys broke the hospital rules and gambled for cigarettes. The boys' physicians reacted to this behaviour in a variety of ways. One physician ignored the episode, others interpreted the behaviour in terms of both individual and group dynamics. In some cases steps were taken to provide the patient with more supportive contact with ancillary personnel.

The group continued to demonstrate their distress. Gestures of leaving the hospital were made, food was refused, and the patient group continued to be tense and rejected the staff. The tension culminated in the escape from the hospital in the late evening of three boys, led by a youth of 17. Preparations for the affair were ostentatious.

In order to open a second-floor window a chair was broken and a steel coat hanger was made into a key. The patients left these lying about for 30 min. before they jumped through the window into some bushes. They hid near the hospital for an hour or more and then headed for the railway tracks, intending to ride out of town on a freight car; at this stage one of the boys became frightened and the leader of the group suggested that they steal a car, which was done. Then the group went to see an adult out-patient who lived in a nearby hotel. Apparently they were trying to find out from him whether adults in their own society approved or disapproved of their action. This man told the boys he could not help them, but that there was money in a drawer. He then left the room, and they took the money.

The boys took the stolen automobile some 200 miles, abandoned it and travelled another 400 miles by train. Then the leader of the group suggested stealing another car, and one of the boys left the group to call his doctor on the telephone. The other two boys then sent a telegram for money to an out-patient, about whom they had previously told their own doctor, 'It's no good telling him secrets because he runs to his doctor and asks him to tell you'. Following this the boys were arrested as they went to the telegraph office to try and collect the funds. In all, the boys were away from the hospital for two days.

AETIOLOGY OF THE DISTURBANCE

(1) *The initial stress*

The initial institutional stress was created by the departure, due to training requirements, of a number of hospital psychiatrists. This was a predictable and inevitable event, as most residency programmes begin on 1 July. At the same time there was a further and unusual stress. Three intermediate level staff physicians who had been actively engaged in patient care were given new supervisory and teaching roles which necessitated the transfer of some of their patients to other doctors. The move was well planned and the staff and patients were aware of its implications, but those patients who were 'losing' their doctors were resentful. In spite of good communications, some members of the staff were anxious about it.

(2) *The reactions to stress*

(a) *Relationship of patients to doctors.* All the patients in the group had hospital physicians who were leaving, or therapists who were going on vacation, except one who was losing his doctor who was about to change his role in the hospital. Patients had been told about this some five weeks prior to the outbreak of the disturbance.

The fear of abandonment and the aggressive reaction which follows is an important factor in producing individual disturbance. Any disturbed behaviour when a patient is in psychotherapy may be due to the internal pressure on the ego caused by the transference neurosis (Fenichel, 1945). The significance of this in relation to the delinquent outbreak was as follows:

The 17-year-old leader of the group, who was losing his doctor because of the latter's change of role, had been readmitted because of a school failure. In the course of his treatment this previously angry boy developed strongly positive feelings for his psychiatrist. He faced the change of physicians with a good deal of distress. He had hoped to succeed in school because he firmly believed, despite the fact that he knew this to be impossible, that if he could get along without the hospital, perhaps he could then see his doctor as an out-patient. This repeated a pattern of his, which was to try to do better, to get his busy executive father to be more interested in him. He had been invariably disappointed in these attempts. His school failure and his re-admission to hospital were similar to situations in which he had been expelled from school and sent home to live with his father. The patient angrily denied that his behaviour in any way related to the threatened loss of his doctor.

It had been agreed with him, prior to his re-admission, that if he became less upset without needing to resort to anti-social behaviour, then his stay in the hospital could be short. When his psychiatrist responded to the gambling episode by interpreting this as a wish to stay longer, the patient perceived this as unfair. As he saw it, nothing was happening to any member of his peer group who took part in the gambling which was anything like 'his punishment'. In addition

he saw his psychiatrist as inconsistent because six months earlier, in a previous gambling episode, his psychiatrist talked about it but had 'done nothing'.

Both the other boys who ran away shared these conscious feelings. Both of them faced in a similar way the prospect of abandonment by a therapist to whom they had previously positive transference feelings.

A 15-year-old had three changes of doctors before coming to the hospital. He had consciously felt these as painful and distressing. When his psychiatrist responded to the gambling by having him go to activities in the hospital only as part of a staff-accompanied group, he perceived himself as being quite unfairly treated, relative to his peers. He felt that his doctor was inconsistent and preferred others, particularly the first boy to whom 'nothing happened'.

The third boy forgot his last therapy hour just before his therapist left on vacation. Shortly afterwards he presented himself to his hospital psychiatrist with an allergic skin reaction and requested hospitalization. This was refused as being unnecessary. Shortly thereafter he left town impulsively without funds and without definite plans. On his return he saw his hospital physician in his office in the hospital. He was told that he should come back to the hospital. He agreed to this but felt his doctor was being unfair and inconsistent because when he had previously asked for hospitalization it was refused, and now he was being admitted when he saw no real necessity for this. In addition he had been told by his physician when he was an out-patient that he should stop an affair he was having with a local girl. Since the psychiatrist had another patient with a similar girl friend, he jealously felt that the other was receiving preferential treatment.

The three boys who absconded had the common emotional problem of feeling their psychiatrists to be unfair and inconsistent. During their treatment, these patients who had come to the hospital feeling bitter, angry and resentful, had allowed themselves to feel warmth and trust. Under the stress of being rejected they reacted with a 'manly denial' of other feelings. Their ego strength was inadequate to cope with the impulse control they needed to contain their anger and hate.

The two boys of the group of five who stayed behind experienced a somewhat similar reality situation to those who absconded: both had psychiatrists who were leaving. However, these two did not feel an acute disappointment over their loss.

An 18-year-old saw his psychiatrist not as a positive identification figure, but rather as a harsh punitive man who demanded things from him and wanted him only as an image of himself. This was an attitude which he had previously felt towards his mother. The psychiatrist was thus for him a rather harsh and punitive external super-ego.

A patient of 15 held his psychiatrist in conscious contempt. He felt him as a man who could be easily manipulated like his parents to give him his own way. He yearned to have a stronger figure in his life, and thus he looked forward hopefully to a 'better new doctor'.

Both these boys had recently commenced psychotherapy, and the temporary loss of the therapist on vacation seemed to be of no great significance to them. These boys had the same conscious feelings as the group who ran away, but these were chronic feelings (that their psychiatrists were unfair, inconsistent, untrustworthy). They did not result from the threatened loss of a loved object, as in the group who became actively delinquent. Nevertheless, since these two knew of the plan to run away and did nothing to prevent it, the split in the group was more apparent than real. Consciously the two boys were supporting the other three in their escape and found the action gratifying. Their conflict about this was demonstrated by the fact that once the boys had left, these two reported it.

(b) *Intra-group relations.* Adding to the anxiety of the group was the fact that four of its members had recently been re-admitted to hospital. The patients had all reacted to this with the feeling that this proved that treatment was no good. The boy who had remained in the hospital saw the returning boys as competitors for status both with the staff and the patients.

The three patients who finally absconded

from the hospital had the following intra-group relationships.

The school failure of the 17-year-old, the leader of the group, led to a severe loss of self-esteem. He said he wished he had never gone, because if he had not, 'he could always kid himself that he could make it'. His declared phantasy to the other boys was that he had come back because a girl in-patient wanted him to. The group knew this was untrue and they knew of his failure.

The boy of 15, whose 'privilege status' had been changed after the gambling episode, had always failed to maintain any increase in his privilege status in the past. After having told the other boys that on this occasion he was going to keep his increased level of freedom, he felt that he had lost face and the group, particularly the girls, were now laughing at him. In addition he did less well at school, he could not keep up with the girls in the same class, and he felt them to be contemptuous of him.

The 17-year-old boy, who returned to the hospital after having left town, had a school phobia which made it impossible for him to go to classes in the hospital. The girl whom his psychiatrist had told him he should give up, was to his knowledge and the rest of the group's, promiscuous.

All three patients had come to treatment with aggressive symptoms which were an attempt to deal with their struggle for a masculine identity. They all were now consciously suffering from feelings of humiliation and inadequacy in their relationship with girls, and they now needed to appear aggressive and masculine. Since the two patients who remained in the hospital were not suffering in this way, this example confirms the statement made in a study of New York gangs that 'the driving forces to gang behaviour are the urge to prove manhood, to dominate and manipulate people in the environment' (Block & Neiderhoffer, 1958).

(3) *Personality characteristics of the patients*

There were some differences in the personalities of those boys who had absconded from the hospital and those who remained. For the first three it was felt, following their initial

clinical examination, that their aggressive activity was a defence against passive homosexual feelings. For the two who remained, one boy was thought to be mainly preoccupied with his own bodily integrity, one dealt with passive feminine fears by phantasying himself as a space explorer. He was obsessively preoccupied with science fiction.

If the historical relationship of the youths to their parents is considered, all of them had been engaged in an aggressive struggle with them prior to their hospitalization. Of the three boys who ran away, two had siblings to whom they were closely attached and who had been their allies against their parents. These two had also been members of delinquent groups prior to hospitalization. One boy was an only child and had never been a member of a gang but had been on the fringe of such activities. He joined the delinquent group only at the last minute. The two remaining patients had very distant and hostile relationships with their siblings and had not been involved in gang delinquencies. This would seem to confirm that children who gang together have previously had a strong relationship with a child companion who shared their disappointment in their relationship to the parents (Burlingham, 1949). The two remaining boys showed on their initial clinical examination a significant fear of being abandoned, and it is perhaps significant that these were both adopted children. The three boys who absconded had previously run away from home.

(4) *Sociological system stresses*

The striking system response to the stress, although intermittent, was one of mutual withdrawal of role groups.

(a) *Withdrawal of physicians.* There were two tendencies in so far as physician-nurse relationships were concerned. On the one hand physicians spent more time with nursing personnel, either discussing patients' care and treatment and actively preparing for the changes which would follow the arrival of the new doctors, or just passing the time of day. On the other hand there was a tendency for

some withdrawal of doctors from nurses. This was particularly felt by the shift which worked in the late afternoon and early evening (from 3.0 to 11.0 p.m.). The apparent withdrawal of interest in their work of some physicians who were leaving was mentioned, and on occasion joked about. An example of doctor-nurse withdrawal is as follows.

An adolescent patient aged 16 was moved on to the floor from another area without any prior discussion with the nursing staff, after he had told his doctor that he was lonely without his friends. The physician took this statement of his at face value and did not discuss the proposed move with the staff. Because of the general upset on the floor, they perceived this move as ill-timed and expressed their resentment about the poor communication by complaining to the doctor's clinical supervisor that he was uncaring and inconsiderate.

(5) *Withdrawal of nurses*

The nursing staff were aware that at times of personnel change there were likely to be disturbed reactions among many patients, and there was evidence that they had strong feelings about the doctors who were leaving. Members of the nursing staff talked freely of their irritation at what would follow the change of doctors. In addition, their routine tasks became particularly important to them, and they tended to spend a large part of their time in the nursing office, writing nursing notes and attending to other formal tasks. Some of the nursing staff seemed to be withdrawing from the patients.

Two boys left the floor without permission and walked out with a group of patients. This behaviour was quite provocative and ostentatious and apparently the boys were inviting the staff to stop them. Several members of the nursing staff saw this occur, seemed 'paralysed', did nothing, and the boys were returned to the floor by an occupational therapist. He expressed the feeling that the nursing staff 'didn't seem to care'. The patients said in effect: 'They saw us go, they didn't stop us, so why was there anything wrong with it?'

It was usual in the hospital for a patient to be offered substitute dishes if he disliked any given

meal. One boy who had been particularly provocative refused lunch and asked for a substitute. One of the nurses he asked 'forgot' his request and another angrily refused, a most unusual response on her part. The patient complained of this to the physician, whose silent response was to feel that the nursing staff was being inefficient, but he failed to communicate with the nurses.

The withdrawal of doctors from nurses and nurses from patients thus created a situation which was interpreted by the patient as 'you don't want us'. This mutual withdrawal was directly responsible for making the escape possible. A physician who was leaving noticed the preparations in one of the lounges, while doing routine rounds of the hospital with the chief nurse. Both he and the nurse reacted with a high degree of unawareness. Although they asked one of the boys whether anything was going on and were told that nothing was, they took no action. It had been known to all the staff that some attempt such as this might be made, and thus all the boys were obliged to stay on the hospital floor in the evening. The actual attempt became successful because of the withdrawal of staff from patients; psychologically there was an unconscious connivance in the escape.

(6) *Patient withdrawal*

Essentially there are two role groups in the patient population, the adolescent and the adult. During the stress situation the adolescents showed the maximum response. There was a tendency for some adults to project some of their own distressed feelings of anger on to the adolescents. They openly expressed the opinion that adolescent patients should not be in the hospital. They began to perceive the adolescent population as being the cause of the irritation, and made them scapegoats for the tension.

The attempt to run away was known to some adult patients before it took place. Normally if anything such as this was planned, an adult patient in the hospital would tell his doctor, asking the doctor to talk to the patient's physician. On this occasion no such step was

taken, and those patients in the adult group were by their withdrawal conniving at the escape. This was also true in the adolescent group itself. One of the adolescent girls who knew of the day of the planned elopement forgot to see her doctor on that morning. Another adolescent patient became physically ill, retreated to bed, and all her contact with the doctor was taken up with the investigation of possible physical illness. Some of the patients mentioned later that they knew of the plan but felt it was not their business to report it because their doctors had enough worries. The conspiracy of silence and mutual withdrawal thus existed between the patients and their physicians, and was not dissimilar to that existing between physicians and nurses.

Both patients and staff, by their withdrawal, were implying to the boys who had become the irritant focus of the overall stress situation that they were unwanted. The ostentatious planning would imply that there was an active wish on the part of the group who ran away to communicate their distress and to be stopped. In fact they were unconsciously told by both staff and patients that they were not an integral part of the community. This bears a remarkable similarity to the general community's attitude towards its adolescent population of 16-19, for whom relatively few resources are provided.

(7) *Restitution*

After the episode there were many discussions of the issues which had caused the difficulty. The doctors recognized their failure to communicate with staff, and vice versa. In addition there was intense discussion about what should be done, and since the local County Attorney indicated that he would take no action unless the hospital wished this, this involved all staff in many discussions about the event.

Once the patients had left the hospital, the overall response of staff and patients was one of guilt and expiation. The girls who had known something of the plan and refused to see their doctors or somatized their anxiety began

to express a great deal of concern about the patients, wondering whether they would be found, and who would look after them.

The staff, particularly those on duty at the time, felt guilty, distressed and responsible. They expressed this, and they became solicitous about the anxiety that the doctors involved must feel. The overall effect of the escape was that the tensions on the floor became focused on the boys who ran away. The general effect within the institution was one of relief. The anxiety felt was now expressed about those patients who were now absent.

On the one hand their return was felt to be inevitable by the patient group, if only because they perceived the medical staff to be so powerful that rescue would occur before they came to any real harm. On the other hand some patients phantasied that the escape would mean that the boys would never return or perhaps might not be re-accepted. The medical staff made intense efforts to find and bring the boys back, which was part of the restitutive process for them.

DISCUSSION

When a system is placed under stress those members of it who are the most vulnerable show the maximum response. Thus stress reactions are seen most evidently in groups of patients in a mental hospital, pupils in approved schools and prisoners. They may be divided into chronic and acute responses. Chronic reactions occur most typically in custodial institutions and may be broadly subdivided into five categories: paranoid, depressed, catatonic, psychopathic and passive neurotic. Although acute reactions may occur in custodial institutions the present study is confined to therapeutic systems.

Acute reactions are subdivided into diffuse and organized (delinquent gang behaviour). The former commonly occur as a result of system stress which may be external or internal. Typical internal stresses which are described are those which produce anxiety in the staff directly or those which occur in the

patient group. If the former are relatively so severe that the system cannot provide its own supports, individual staff members will react according to their own personality structure but there is the likelihood that role groups will withdraw from each other, thus creating a stressful situation for the patients. They will react in their turn, enhancing the institutional stress. If the disturbance starts within the patient group, either because the staff make intolerable demands upon it or there are struggles within the group, the extent of the disturbance is a function of the adequacy of the staff's response.

In a situation in which there are adolescents and adults together, since the former react more overtly, adolescence being an age of action, the adolescent group tends to have the anger and anxiety of the adult group projected on to it. The adolescent group will then perceive the adults as rejecting, conniving with them, and colluding (Laing & Esterson, 1958) to extrude them from the system as a whole.

This weakening of the external structure, upon which patients with poor impulse control rely for support, then leads to an increasing cycle of regressive and disturbed behaviour. There is no evidence from the present study that these factors in themselves lead to organized delinquent outbreaks, although it appears necessary for them to occur. Thus in terms of society at large it is not enough to assume that delinquent outbreaks are solely a function of society under stress, although by implication any attempt to prevent delinquency in the community requires some aetiological study of the instability of the society immediately involved, and some reparative work with it.

This study would indicate that organized delinquent outbreaks require a group leader to initiate the action who shares an acute conflict at both a conscious (Redl, 1949) and unconscious level with members of the group. In addition, in this study, the delinquent group showed common personality characteristics. The conflict clearly related to acute disappointment with loved objects who were perceived as

rejecting. It would seem important to discover whether in society at large this is a significant aetiological factor in a potentially delinquent group entering into overt action. The success of the outbreak was a function of the unconscious collusion of some parts of the environment in which the patients lived. This is not dissimilar to the conscious and unconscious provocation of disturbed behaviour seen in family groups (Johnson, 1956; Miller, 1958). Sociological processes were thus responsible for the diffuse general disturbance, but the most important aetiological factor in the organized collective disturbance would seem to be the personality structure of the individual and the relationships he has with those figures within his environment who are of immediate significance to him—his peer group and significant adults. In this example, the behaviour was a result of the acting out of an acutely negative transference neurosis.

In all institutions which treat adolescents, the patient population develops in its relationship with significant adults, feelings which reproduce significant infantile experiences. In the situation reported, the important adults were psychiatrists, but the same responses are likely with teachers and other professional personnel.

When adolescents are being treated in institutions, disturbed and delinquent episodes occur from time to time; clearly they are never accidental. During processes of restitution it is possible to create a more helpful therapeutic environment, and in any given institution, if aetiological factors around a disturbance are studied, it is possible to prognosticate when such occurrences are likely to take place and therapeutic steps can be taken to abate them. Times when system stress is evident are the times when disturbance is likely. This stress may be external or may take place in one or other of the role groups within the system. It may also be created when one role group makes intolerable demands on another. The type of response to the stress will depend on the personality of the individuals involved and the relative balance of sociopathic to non-sociopathic individuals within a group. It will also depend on the support individuals in a group get from one another and from the significant adults in their environment. The stress response is always anti-social but the destructive quality of it may be externalized, as in the examples shown, or internalized in a chronic fashion, as in hospital wards which contain large groups of dilapidated, depressed or catatonic patients.

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I

THE OEDIPUS COMPLEX

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On the formula which guides this paper, the behaviour to be explained is that of the patient towards his parents. The conditions upon which this behaviour, represented by two bonds of the triangle, is taken to be dependent are constituted by the other four bonds. Admittedly, this is an artificially simple formula—although legitimately so—for it regards the patient's behaviours as reactions to his

parents' actions, instead of regarding the behaviours both of parents and patient as interactions. Oedipus's behaviour is thus to be explained by reference to the behaviours of Laius and Jocasta towards him and towards each other.

These four bonds had several remarkable features which Freud did not mention. Of special interest are the following (Rank, 1912; Devereux, 1953; Lemprière, 1829). *Father to son*: Laius instructed Jocasta to destroy Oedipus at birth, because he had been told by the oracle that he would perish at the hands of his son. Later, on the road to Thebes, anticipating the rivalry of Oedipus, he started the fight which ended in his death. *Father to mother*: Except on the occasion on which Oedipus was conceived, when he was intoxicated, Laius refrained from sexual intercourse with Jocasta, because of the oracle's warning, which, incidentally, arose out of Pelops's curse on him for his kidnapping and homosexual rape of Chrysippus. This reason for refusing intercourse we may regard as a morbid one, and we may also conclude—*Mother to father*—that Jocasta derived little satisfaction from her marriage with him. *Mother to son*: She did not obey Laius's order in full, but she was responsible nevertheless for the exposure and abandonment of Oedipus, for whom she had no opportunity to develop maternal feelings. She did not consent to marriage and intercourse with Oedipus until after her marriage with Laius had come to an end. In her relationship with her son she then derived satisfactions which she had been denied in her relationship with her husband.

These features have been chosen for mention because they prepare for points to be made further on in this paper. There would have been other possibilities, for there are many variations in the legend. Fromm (1959), for instance, selected those features which serve to show that the essence of the Oedipus complex is the son's rebellion against an authority of the father rooted in the patriarchal structure of society, incestuous strivings towards the mother being an inessential com-

ponent. The prize won by Oedipus for solving the Sphinx's riddle was the throne; with the throne went the widow. There would be no conflict between father and son, Fromm claims, following Malinowski, if there were not the strong patriarchal authority. The bond to the mother, he asserts too, is not essentially a sexual one and depends upon 'the dominating attitude' of the mother.

Many authors have taken the view that the form of the Oedipus complex is dependent upon the other bonds. Fenichel (1945, p. 95), for instance, commented thus: '...the form of the Oedipus complex is modified by the parents' attitudes towards each other, amongst other things'. Suttie (1935) was more specific: 'The Oedipus complex is largely contingent on particular modes of rearing and forms of family structure, culture and racial character.' It is not universal, he asserted, 'but contingent upon certain circumstances affecting the mother's character and affective relationship to her son and husband respectively'. 'The conclusive barrier to the Oedipus wish', he added, 'is mother would never consent.' That is, as Freud (1924, p. 419) suggested, '...the complex becomes extinguished by its lack of success...'

Considering the theoretical interest of the Oedipus complex, it is at first sight surprising how few have been the papers in which the conditions of occurrence of such major manifestations of the complex as mother-son incest, patricide and matricide have been discussed with reference to particular cases. One reason for this has been that such cases are relatively uncommon. When they do occur, they tend to be dealt with by courts of justice; opportunities for psychopathological examination are then restricted. Another reason is that psychoanalysts have tended to regard them as having only marginal relevance, arguing that they reveal not the conditions of occurrence of oedipal wishes, but the conditions in which oedipal conflicts have remained unresolved, and the restraints on the expression of the wishes have failed. The validity of the latter reason is doubtful, and, facing the risks of

irrelevance, a brief review will be given of the recent literature on the conditions in which the major manifestations occur. But to take incest and parricide as typical manifestations would be to attach a much more literal and specific meaning to the complex than Freud ever intended (*vide* MacCurdy, 1925, p. 93).

INCEST BY MOTHER AND SON

Incest by mother and son is uncommon, absolutely and by comparison with incest by father and daughter. In the series of sexual offences discussed by Radzinowicz (1957) there were seventy-eight cases of incest. In thirty-one of these the offenders were father and daughter; in ten, brother and sister. Cases of these kinds are not uncommonly met with in medical practice. They tend to occur, or at any rate to come to light, in poor families living in crowded quarters. There was no case of incest by mother and son in Radzinowicz's series, and Karpman (1954) in his monograph reports only one case (*case* 93). In this case the father had died when the son was 4-5 years old. The son committed the offence when drunk, the mother resisting and later reporting it. In the only proved case I have met with personally, the mother was a psychotic imbecile, with an I.Q. of 42. She had seduced and had had intercourse on several occasions with her son, also a psychotic imbecile, with an I.Q. of 55. The father was unmoved when the offences were reported by a neighbour.

The investigation of patients suggests occasionally that the patient has had intercourse with his mother. This appears to have been so in *case* 31 of Alanen's (1958) series of schizophrenics. This patient's father had died when he was 11 years old, the incest occurring when he was 12. In his *case* 32, Stekel (1949) described the offending mother as a nymphomaniac. The father had suffered for ten years from *Tabes dorsalis* and was presumably impotent. The son was suffering from a severe obsessional neurosis.

Levy (1943) reports the occurrence of several manifestations of oedipal conflicts in

his series of twenty cases of over-protecting mothers. There were six boys who had slept in their mother's bed long past infancy. One of them subsequently made a proposal of intercourse to his mother. Another accused his mother of being pregnant. Several showed precocious sexual activity, in some cases approaches being made to older women. Two sons showed flight from the mother during adolescence. A follow-up of the cases, incidentally, revealed no evidence of impotence or homosexuality.

Levy concluded from his study that there was a high degree of sexual and social incompatibility in the marriages of the over-protecting mothers; in only three out of twenty cases were the mother and father well adjusted to each other sexually and socially. There is too little evidence to draw any conclusion about the circumstances in which incest by mother and son occurs.

PATRICIDE

A similar lack of evidence prevents any conclusion on the circumstances in which patricide occurs. A librarian's thorough, although not exhaustive, search through the recent psychiatric literature brought to light five papers only in which cases of patricide were reported. A paper by Rascovsky (1945) reported six cases, but none in sufficient detail to allow conclusions about the psychodynamics. However, in one case (R.R.) the father was an alcoholic. In three other cases (E.K., J.A.V. and E.V.) there were suggestions that the father had ill-treated the son. In one of these cases the father started the fight, which ended in his death, by attacking the son with a knife.

One short paper by Carriat, Ollivier & Bobis (1956) described a case in which a son aged 34 years killed his father aged 82 under the influence of delusions of uncertain meaning. Sheehan-Dare's (1955) patient, Miles Gifford, was a single man who had been ill with a psychosis from his early childhood. At the age of 26 he killed both parents, his father first and immediately afterwards his mother.

Throughout his life his father had imposed a strict, often unreasonable and always unsympathetic discipline. Nothing has been reported of the relationships of mother and father to each other. His mother had given him over in early childhood to the care of a nurse. Raizen's (1960) patient also killed both parents, but the mother was the primary victim in this case, which will be discussed below as one of matricide.

De Waele (1957) has provided much useful information about his patient, Adolphe, who was of psychopathic personality. Adolphe's mother and father separated when he was born. His mother looked after him for 3-4 months. She then gave him over to the care of various relatives. He was also resident for some years in institutions. At 12 years old he went again to live with his mother. At 14 years old they were rejoined, more as pensioner than as husband, by the father, who adopted a brutal, tyrannous discipline and showed jealousy of the mother's interest in the son. During a temporary absence of the mother, the son, now aged 22 years, killed the father under extreme provocation.

The last case, in particular, and in a lesser degree possibly also Sheehan-Dare's case, shows points of resemblance to the case of Oedipus: the abandonment by the parents in infancy, the lack of an affectionate relationship between son and father, the father's jealousy and hostility when the family was subsequently reunited, the partial or complete rejection of the son as a child by the mother, and the lack of affection in the relationship between mother and father; also the father provoked the attack on him.

MATRICIDE

There is a more extensive literature on matricide, and some of the points about ten cases are summarized in the list below. Included in the list, for purposes of comparison, are four other notable cases, two from literature and two from history: Orestes, Hamlet, Nero and John Perry (Davis, 1959).

Psychoanalysts have assumed that matri-

cide is an expression of the Oedipus complex, the murder being committed when incestuous wishes become unendurable. The case of Hamlet (Freud, 1953, pp. 264-6; Jones, 1949) has been taken as a model; although he did not in fact kill his mother, he brought about her death and killed his rival, who incidentally had first attempted to kill him. The factors were his mother's adultery and 'o'er-hasty' marriage with his father's murderer. The case is probably unusual in that there had been a good relationship between his mother and father (Act 1, Sc. II, lines 140-6), although she had been unfaithful. Remember too that Claudius had usurped the throne, which was Hamlet's (Wilson, 1951).

In all the cases in the list the murderers were sons, but there is one daughter for every three sons amongst matricides admitted to Broadmoor (Gould, 1958); in my only personal case the patient was a daughter. The sons are in the late teens or early twenties. The families tend to be small. Perhaps the most striking feature is that in at least four cases the father was absent from the home from early in the son's childhood, and there was no opportunity for a sympathetic identification with him.

The relationship with the mother, on the other hand, was a close one in most cases, although it tended also to be unsatisfactory in various respects. The circumstances were mostly such that it tended to become closer during the years of puberty. This was especially so in Raizen's case. The son lived alone with his mother from 11 to 14 years old, while his father was away in the army. During these years and subsequently the mother behaved seductively towards him. In several cases the murder of the mother took place when the mother had taken a lover or remarried, in Raizen's case when she had become reconciled with her husband. Orestes, Hamlet and John Perry killed their rivals as well, as did Raizen's patient.

It appears that the son resorts to matricide when anxieties arising out of his relationship to his mother become intense. Like Nero, he has to take away his mother's life in order to

The literature on matricide

	Age	Position in sibship	Marital status	
Orestes	?	1/2	S.	M. killed F. and remarried
Hamlet	? 18	1/1	S.	M. committed adultery with and married F.'s murderer
Nero	?	?	S.	M. remarried after F.'s death, killed step-F., incest with son
John Perry	25	2/2	S.	F. died. M. favoured older brother
Authors				
Arnfred (1946)	17	1/1	S.	F. died, 6 years old
Galvin & Macdonald (1959)	23	2/2	M.	M. left by F., 18 months old; remarried, 9 years old
Hill & Sargant (1943)	20	1/1	S.	F. not mentioned, presumably absent
Lindner (1948)	18	2/2	S.	M. divorced F., 3 years old; took lovers, 12 years old
Meerlo (1959)	14	1/1	S.	M. widowed
O'Connor (1954)	25	1/1	S.	M. and F. separated, early childhood
Raizen (1960)	22	1/1	S.	F. away, 11 to 14 years old
Sheehan-Dare (1955)	26	2/2	S.	Normal family structure
Wertham (1947)	17	1/2	S.	F. died, 11 years old. M. took lovers.
Winfield & Ozturk (1959)	13	1/1	S.	Normal family structure

save himself from ruin. It does not necessarily follow, but it seems reasonable to suppose that incestuous wishes and their frustration make a major contribution to the anxieties. The crucial years in the development of the relationship between mother and son tend to be those of puberty.

The study of cases of matricide tells us something about the circumstances in which intense anxieties arise out of the relationship to the mother. Matricide is not then the only possible reaction. The son tends also to attack his rival. He may attempt suicide or like Hamlet contemplate it. Sometimes he takes flight. In nearly every case he develops a psychosis as well, or suffers already from a psychosis. We may ask, therefore: does schizophrenia develop in circumstances like those in which matricide occurs? In what degree do oedipal conflicts enter into the aetiology of schizophrenia?

II

A psychological theory of schizophrenia starts with the assumption that schizophrenia develops—i.e. certain distinctive psychological mechanisms come into operation—when in certain circumstances anxiety arising in certain ways reaches a certain intensity. This assumption sets investigators the task of discovering what the relevant circumstances are, in what ways the anxiety may arise, and what the critical intensity is. The hypotheses to be discussed here would provide, if they are eventually shown to be valid, at most a crude and partial definition of one way in which the anxiety may arise. They are as follows. In young male patients, the anxiety arises out of the relationship with the mother. The illness begins when a change in this relationship increases the anxiety. The frustration of incestuous wishes contributes to this anxiety.

Table 1. *A series of cases of schizophrenia*

No.	Age of onset	Age at referral	Position in sibship	Duration of contact with case	Outcome, degree of disability
1	19	20	1/1	10 years	Severe
2	24	24	2/3	4 years	Severe
3	16	22	1/3	8 years	Moderate, working
4	16	16	2/2	9 years	Moderate, working
5	11	16	1/2	3 years	Moderate, working
6	11	17	1 = 2*	8 months	Moderate
7	20	20		6 years	Severe
8	22	22	2/3	9 months	Slight, working abroad
9	16	17	1/2	4 years	Moderate, in hospital
10	19	20	2/2	3 years	Moderate, working
11	14	17	1/2	3 years	Slight, working
12	?	20	1/1	3 years	Severe, in hospital
13	21	22	1/2	2 years	Severe
14	19	19	1/1	18 months	Slight, working
15	15	15	2/3	8 months	Moderate

* Dizygotic twins of different sex.

These hypotheses might be supported by reference to many observations reported in the literature. Here they will be supported by the findings in a series of fifteen cases. These are all the cases in my files satisfying the following arbitrary criteria. The patient was male. He had passed through puberty and was less than 25 years old at the time of the referral to me. His pre-morbid I.Q. was above 85. He was treated by me for six months or more. One or other parent had been interviewed. The final diagnosis was schizophrenia.

Table 1 gives some details of the cases, which are listed in the order in which they were referred. Before presenting the findings with a direct bearing on the hypotheses, certain other points will be made.

The relationship between the parents (vide Table 2). In no case was this relationship a fully sound one. In four cases it had been broken altogether, by death in two cases, and divorce in two cases. In nine further cases the parents were 'estranged', in the sense that they were on bad terms, and had ceased to have sexual intercourse with each other for 5 years or more before the date of referral; in three of these cases sexual intercourse had

ceased at the patient's birth. In two cases only was the relationship a normal one at the time of onset of the son's illness, but in both of them it had been broken for several years while the father had been away from home during the war.

(The published data on the frequency of intercourse of married couples suggest that the second criterion of 'estrangement' would be satisfied in about one in a hundred cases in a representative sample of the general population of such couples of similar ages. The probability that it would be satisfied in nine cases in a sample of fifteen cases is extremely small. It can be concluded, therefore, that the sample was a special one.)

The relationship between father and son. In no case had there been at any time a good relationship between father and son—vide Table 3. None of the sons had made a strong positive identification with his father. In four cases the father had left the home by death or divorce. In five cases the relationship was a shallow one; in three of these cases the father had been 'excluded', in the sense that he had played little or no part in the son's upbringing. In six cases the father had been rejecting, and

there was marked antipathy on both sides. In three of these cases, and possibly in a fourth (9), the father had shown jealousy of the mother's attentions to the son.

The relationship between mother and son. In every case the relationship between mother and son was one that has been found to be typical in cases of schizophrenia. It was a

Table 2. *Relationship between mother and father*

No.	Age of onset	
1	19	F. died, 8 years old
2	24	'Estranged'
3	16	'Estranged'; F. absent, 10-16 years old
4	16	'Estranged'
5	11	Normal; F. absent, 6-11 years old
6	11	M. divorced F., 5 years old; remarried, 11 years old
7	20	M. divorced F., 5 years old; took lovers, remarried
8	22	'Estranged'
9	16	Normal; F. absent, 2-6 years old
10	19	'Estranged', from birth
11	14	F. died, 2 years old; M. remarried 7 years old
12	?	'Estranged', from birth
13	21	'Estranged'
14	19	'Estranged', from birth; F. absent, 2-6 years old
15	15	'Estranged'

Table 3. *Relationship between father and son*

No.	Age of onset	
1	19	F. died, 8 years old
2	24	Shallow
3	16	F. absent, 10-16 years old; rejecting
4	16	Shallow
5	11	F. absent, 6-11 years old; jealous, rejecting, strict; intense antipathy, fought once
6	11	F. divorced, 5 years old
7	20	F. divorced, 5 years old
8	22	Shallow, F. excluded
9	19	F. rejecting, strict
10	19	Shallow, F. excluded
11	14	F. died, 2 years old; step-father disinterested
12	?	F. jealous, rejecting; attacked once by son
13	21	F. jealous, rejecting, strict; blows exchanged often
14	19	Shallow, F. excluded
15	15	Rejecting; son has intense antipathy to F.

close one, and played a central part in the son's life. The mother tended to be dependent on the son for satisfactions. At the same time she tended to be possessive, dominating, over-protective and indulgent, and, although ambivalent, also in a degree rejecting.

The events associated with the onset of the illness. In twelve cases it was possible to identify with confidence the event which precipitated the illness. Were these events of a kind which would bring about directly or indirectly a change in the relationship between mother and son? In ten cases an affirmative answer could be given; in one other case (1), doubtfully so. In four cases (2, 11, 12, 13) no such answer was possible. Brief details are given in the notes below, with the symptoms which were taken to be manifestations of oedipal conflicts. The ages given are those of the son, unless otherwise stated.

(1) The illness began shortly after the death of his mother's father—19 years old—to whom she was closely attached. She then became more dependent on the son, and more possessive.

(2) The significance to the patient of his sister's death—24 years old—could not be elucidated.

(3) He slept in his mother's bed until he was 5 years old. Leaving home to go overseas on National Service, his father told him that he should take the father's place in the family. He became upset, and showed some psychotic symptoms, when at 14 years old his mother was visited by another man. A definite psychosis began soon after the father's return, at 16 years old. Excessive masturbation was then a prominent symptom, to which he said he was excited by thoughts of sexual contact with his mother. Soon afterwards he stopped working and began to drink heavily.

(4) A few days after his father had been taken into hospital seriously ill with a coronary thrombosis—16 years old—he burst into his mother's bedroom after she had gone to bed. She attributed a sexual significance to this behaviour, and reproached him. In her account of the incident she laid stress on his

reply, which was: 'When the king dies, the son takes the throne.'

(5) His personality underwent a marked change soon after his father's return home after 5 years absence—11 years old—and there was a gradual deterioration in his behaviour. Antipathy to the father was a prominent feature of his illness.

(6) He tried to hang himself a few days after his mother had told him of her intention to remarry—11 years old. He reproached her for her infidelity to him.

(7) His first psychotic break occurred shortly after his mother brought her lover to live in the home—20 years old. His second break occurred at about the time of her subsequent marriage to another man—24 years old. In both attacks he was preoccupied with his mother's sexual life, and held delusions that people were talking about her immorality.

(8) Mother and son enjoyed a close companionship, and for many years played the game in their talk that the son was her husband and the father of his younger brother. He was promiscuous sexually from a relatively early age, and engaged in at least one homosexual affair. His mother became very disturbed when she learnt of his friendship with a woman of 33 years, and of this woman's pregnancy. After several rows the son developed a psychosis at 22 years old. At its start he tried to poison his mother and to hang himself. He made a partial recovery when he left home and improved further when he emigrated to Africa.

(9) He became greatly concerned about his mother when she went into hospital to submit to hysterectomy, and anxiety arising in this way was the first sign of his illness—16 years old. It was usual for him to discuss his masturbation habits with her.

(10) The first symptom—20 years old—was his persistent accusation of a woman of his mother's age that she was immoral; she rebuffed a sexual proposal by him. Soon after this event he began to visit his mother's sister, a respectable married woman, and openly demanded sexual intercourse with her.

(11) At the beginning of his acute illness—at 14 years old—he attacked his mother with a knife.

(12) Little is known of the circumstances in which his illness began.

(13) A definite psychosis began shortly after he went into the army on National Service.

(14) The son became sexually promiscuous at a relatively early age, both with men and women. When at 19 years old he told his mother of his 'engagement' to a woman 9 years older, she became acutely distressed and took an over-dose of barbiturates. A few days later he developed an acute psychosis.

(15) Following some set-backs in his business, there was open discord between mother and father. The mother deprecated her husband and took her son's side in the son's complaints against him. The son's antipathy to the father, his preoccupation with sexual matters and his over-frank conversation with his mother were prominent features of his illness, which began at 15 years old.

It seems reasonable to argue that the events reported summarily above amounted in most cases to a crisis in the relationship between mother and patient. This view, which is strengthened by a detailed scrutiny of the case material, leads to the hypothesis that one source of the anxiety in schizophrenia in young males is the relationship with the mother, and that the psychosis begins when anxiety from this source becomes intense.

It also appears that frustration of incestuous wishes contributes to the anxiety in an important degree. In support of this hypothesis can be brought the facts that in four cases (3, 5, 6, 7) the event precipitating the psychosis was the appearance of a rival, and that in five cases (3, 4, 6, 7, 15) the son showed a definite sexual interest in his mother at the start of the psychosis. It can also be argued that the sexual interest in older women shown by three cases (8, 10, 14) represented the displacement of incestuous wishes. It would be difficult to interpret the son's distress (9) about his mother's hysterectomy without supposing

that sexual interest in the mother was involved. Rejection by the mother precipitated the breakdown in one case (11) and probably also in a second (12). The frustration of incestuous wishes was of course not the only source of anxiety in these cases.

Hatred for the father was clearly shown by the minority only (5, 12, 13, 15); it was perhaps felt by others, but was less clearly expressed. In the cases in which hatred was clearly shown, the father's rejection of the son, his hostility and jealousy were apparent. These feelings on the part of the father went beyond what is implied in Fromm's concept of a strong patriarchal authority. In some cases, but not all, in which the son showed a sexual interest in the mother, the father was absent from the home or had been excluded.

The manifestations of oedipal conflicts were obvious at the beginning of the illnesses. They were much less obvious in later stages. Some of the series have been followed through several years, and it would have been difficult to point to unmistakable evidence of oedipal conflicts in the features of the chronic illness, although they were often revealed when psychotherapy was attempted. It should be noted that the patients in the series broke down at or soon after puberty. In a series of older patients, obvious manifestations of oedipal conflicts were fewer; for one thing, many of these patients had left home.

The importance of oedipal conflicts in schizophrenia has of course been fully recognized by psychoanalysts and others (e.g. Fenichel, 1945; MacCurdy, 1925). It seems to have been underestimated in recent studies of the families of schizophrenics, because investigators have not looked closely enough at the symptoms at the beginning of the illness, and because they have been concerned more with states and personalities than with processes. Previous investigators have also tended to suppose that oedipal conflicts are merely revealed in schizophrenia. In this paper these conflicts are identified as a source of anxiety and as playing an important part in the aetiology.

CONCLUSION

This review of the conditions of occurrence of the major manifestations of the Oedipus complex shows that, when they occur, there tends to have been a failure of identification with the father, a poor relationship between mother and father and an abnormal relationship between mother and son. These conditions are not independent of one another. The case material considered in detail suggests that the years from 10 to 16 years old are crucial in the development of the relationship between son and mother. It is sometime during these years that the son who is to suffer from schizophrenia in his teens or early twenties becomes more firmly attached, in a more definitely sexual way, to his mother instead of beginning to make friendships outside the family with girls of his own age. This is the setting of the conflicts from which intense anxiety may arise. A striking feature in

eleven cases was that the patient had never enjoyed any sort of normal friendship with a girl. One patient (9) suffered a severe relapse when he embarked upon an affair with a girl of loose morals. Only three patients had been able to achieve a relationship with a girl. Of these, two (8, 14) had been sexually promiscuous; one (11) had made a good relationship with a 14-year-old girl, outside the law but surviving two pregnancies and several appearances in Court. It is probably of significance that these are the three patients who have made the greatest degree of recovery.

Whatever its short-comings, the term Oedipus complex is still a convenient one as a compendious description of a pattern of relationships within the family. It can be replaced when more is known of the nature of the bonds which link the members of a family and of the changes which these bonds undergo at a child's puberty.

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Analytic implications of the test situation

By F. H. STRAUSS*

What does psychological testing mean to the patient? How will the test contents and results be influenced by the patient's experience of the situation with particular reference to his reactions to the tester, and what consequences, if any, will the experience have upon the patient?

From the way in which these questions are asked, it is clear that my view of the test situation is an analytical one. Some of my views will therefore overlap with those of Schafer (1954, 1958).

The test situation like the analytical session is 'artificial' in the sense that it lies outside the patient's ordinary life. Because of this, it has value in providing a sample of the patient's behavioural responses to unfamiliar situations.

The test situation is a complex one; it cannot be thought of merely in terms of a reaction to an external threat. Not only have stimuli from without but also those from within to be taken into consideration. It is my contention that the test situation may induce experiences of archetypal or transpersonal images and thereby lead to dynamic developments which are directly relevant to the purposes of testing. Following Jung's concept of the archetypes, I understand the term 'archetypal' in this context as referring to experiences of a general nature which may occur whatever the patient's personal and social background.

Many patients experience the test situation in basically the same way although their individual modes of defence may differ. This is true of patients coming from two different

hospital backgrounds and whom I have tested in different phases of their hospital stay. The Social Rehabilitation Unit (now Henderson Hospital) is run along the lines of a therapeutic community (Maxwell Jones, 1953) but the rest of the hospital (Belmont Hospital) has a different orientation. In seeing Unit patients I have to deal largely with patients who are familiar with me (Strauss, 1955) while the hospital patients often do not know me at all. The majority of Unit patients are anti-social, and it must therefore be pointed out that the observations in this paper were made on patients with a variety of diagnoses, and not only on those for whom the relationship to authority is a special problem.

The patient's feelings about being individually tested are usually not ventilated for quite a time. If the strain and stress of the test situation are too strong, the patient usually asks questions such as 'Why do I have to do this?', or 'Why did you pick on me?' However, patients generally regard the investigation as intended to help them. It is mainly those with strong paranoid features who cannot respond like this.

In cognitive testing the role of the psychologist is traditionally one of supporting, encouraging, and praising in order to obtain optimum results. With personality tests the role of the tester is bound to be different since the achievement of useful results does not necessarily depend on the tester encouraging the patient throughout the test. Nevertheless, in accordance with tradition, the tester's basic attitude remains a benevolent one.

It seems that despite the tester's benevolent role the patient cannot lose the fear of being judged by the powerful father, an experience which transcends the personal history of the patient. Besides, an experience like this will

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elicit ambivalent reactions in the patient, as will be shown later.

In this connexion two studies will be briefly mentioned. The first is by Thomas A. Wickes, Jr. (1956). The effects of perfunctory verbal comments and non-verbal actions on test results were systematically studied. Wickes states that the findings of the study suggest that such comments as 'good' or 'fine' and such actions as smiling and nodding by examiners have a decided effect upon test results. Thus, he concludes, the experiment indicated that 'examiners should be alert to the fact that even under presumably "standardized" conditions it is possible for their behaviour to be reflected in test results'.

It is likely that the influence of the tester on test results was due to the ambivalent attitude produced by the test situation in the testee. With his benevolent behaviour, the tester succeeded in bringing to the fore one side of the ambivalent attitude which was expressed in associations of a constructive nature.

The second study is by Lewis Bernstein (1956). This study showed that the presence or absence of the tester could significantly influence the content of Thematic Apperception Test stories, oral responses were compared with those written down in the tester's absence, and although oral and written responses were not appreciably different in the presence of the tester, his absence did cause important differences in their written responses. Bernstein thinks that this may have been due to the subject's expectations related to the tester's evaluation of his productions.

This recalls the patient's fear of being judged by the powerful tester, mentioned before. A few examples may illustrate what was meant. It seems likely that the reactions described were not due to my 'personal' behaviour, but were brought to the test situation by the patients' projections.

In the middle of the T.A.T. a patient said that he was not free to interpret the pictures since his stories might reveal something detrimental to himself. The tester might prevent him from getting a

job he liked, if he thought that the patient had the temperament of the boy in the 'Operation Scene' of whom he had just been speaking. Another patient who knew me well and had a positive attitude to me remarked after the T.A.T. 'You are a very crafty man and have chosen your cards very cleverly.' Lastly, a girl, who did not show any overt signs of resisting the test situation, said after the T.A.T., 'Is this all held against me?'—a remark reminiscent of the fear of the last judgement.

Quite in contrast to projective tests, cognitive tests present the patient with a fairly familiar situation which may, nevertheless, revive a traumatic experience. His anxieties may be stirred, and consequently the tester will appear stern and disapproving, despite his traditional role of being encouraging and praising. However, since the patient is expected to use his ego facilities he will succeed, as a rule, in maintaining his defences. Projective tests, on the other hand, constitute less of a 'task' than a 'trial'.

It is when confronted with projective tests that the patient feels the demands upon him mounting, and reacts accordingly. The Rorschach Test is not unique in arousing anxiety; moreover, the patient is usually able to maintain his impression that his responses to the card do not give him away. Anxiety about giving something away is more often stirred up by the Thematic Apperception technique, for the patient is more aware of talking about himself. Schafer (1954) has stated that because the patient deals with pictures from everyday life in the T.A.T., it reveals more of the patient's adaptive efforts than the Rorschach which is unstructured and utterly unfamiliar. This implies that in the T.A.T. the patient feels challenged to cope with conflicts, be they latent or manifest, which he recognizes or senses as belonging to his own life.

Shneidman's 'Make a Picture Story' test puts the patient under a stress similar to that imposed by the T.A.T. If the test situation is regarded primarily as a trial, as something to be endured, it would appear that the stress is significantly diminished by permitting the

patient to choose the figures for the background himself.

So far I have been concerned on the one hand with the test situation as constituting a threat to the patient, and on the other with the patient's feeling that the tests are meant to help him. The patient is in a quandry because of his ambivalent feelings towards the test situation and towards the tester in particular. Looking at the tester as an omniscient being, the patient fears being found out, but also wishes for this, so as to be understood and accepted. He may make attempts to gain the tester's approval and love, in order to make sure that his phantasies will be tolerated, or else he may try to seduce the tester by his phantasies since the feeling of being judged prevails from the start. The patient may become more aggressive towards the tester, in an attempt to cope with his fears, an attempt which in certain cases may be understood as a constructive effort because it represents the ego's struggle for preservation. In contrast, borderline psychotics, with weak egos, produce associations and stories of an incoherent, autistic, archaic, and morbid nature. It seems that a large number of them do not experience the tester as an invader. I think that in such cases the ego is of a fluid nature, i.e. there are hardly any boundaries. As a result of this the patient will feel identified with the invading tester.

To illustrate these views on the test situation some case material chosen from T.A.T. protocols will now be presented. With reference to the problem of interpretation, the reader is referred to a paper by Lyle, Gilchrist & Groh (1958) in which they report on three blind interpretations of a T.A.T. record made by three psychologists, each using a different theoretical framework, based on the theories of Freud, Jung and Melanie Klein, respectively. A high degree of agreement with one another was attained. The authors stress the need to interpret projective tests within some theoretical framework; they suggest, however, that these tests are not to be regarded as tests (i.e. measuring instruments) but as techniques which provide thematic and perceptual material for

analysis. Similar views have been expressed by other authors (in particular Shneidman, 1952).

Case 1. Sam, aged 26, and Jewish, had been complaining of various physical and psychological symptoms for a number of years. Moreover, he felt generally discontented and inadequate in the occupational, social, and sexual fields. Soon after admission to the Unit, Sam joined my therapeutic group of which he seemed to become fond; but after a couple of months he suddenly stopped attending.

Approximately 3 weeks later he was given the T.A.T. In the preceding interview, he had said that he felt unsettled because another patient had threatened to hit and kill him. This threat had resulted in pains all over his body. He complained of 'having no guts' and went on to speak of his father, who was weak, and wanted everything done for him. In passing, he mentioned that he wanted to find a purpose in life. He could understand certain things much better now. He seemed to be proud that he had been right in his judgement of other patients. They called him an amateur psychiatrist. But he was still tied to his mother—why did he still get these pains?

Sam's stories will now be presented, each one followed by a short comment.

Boy with violin—card 1

I am not much good at such things...he... does not know what to do, whether to play more, he may have played a piece badly,...shall I practise more?... He has got a lot in his mind. Just... he seems to be on the edge of succeeding, of trying again, but is held up, stopped—he is thinking what should he do. There is not much more. (Encouragement; what will he do?) He is going to pick up the violin again, he will try again. The expression on his face is vague, he has got one eye half open, one closed, he is thinking deeply what he should do. Is it worth all the effort, all the practice?

Although the opening remark 'I am not much good at such things' is not unusual, it is significant in relation to the transference. The patient informs me that he has not much to offer. Likewise, the question at the end 'Is it worth all the effort?' seems to be related to the test situation. One is reminded of his remark in the interview that he

had no guts. The remark immediately following encouragement, 'He will try again', leaves no doubt that he was addressing me. Shortly afterwards came the strange remark, 'one eye half open, one closed', by which his ambivalence was clearly stated. The closed eye points to his being drawn towards the world of his thoughts and phantasies which seemed to be more attractive than the external world which I represented at that moment.

Mother and son—card 6 BM

Hm...it looks like...he has got something towards mother, something which is...he seems sorry about it, he is ashamed, he does not want to hurt her, she does not want to believe him, he does not feel happy, he may not be happy even if he said it. I got the impression she looks out of the window—he has to walk off with his head down—he is very unhappy. She is very proud—I cannot see them coming together. I am thinking of myself. Is it possible if I say no coming together—is it this what will happen? He has managed to say, I never came to that point.

This picture reflects Sam's problem of being tied to the mother, and the anxiety or even anguish of separation, a problem with which he was much preoccupied in the Unit. One cannot help feeling that the words 'he has managed to say, I never came to that point' refer to the situation when he left my group without saying anything. It appears that in the group he was acting out his mother transference.

I shall leave out the next story in which Sam continued to project the mother image on to me. His ambivalent feelings were increasing.

Operation scene—card 8 BM

It could be a dream. This could be a gun. This could be a religious man (last one in background). I got the impression that he is not unconscious—the man is feeling pain. There is a boy, there is a window, is it a dream? The boy gives the impression of wanting to hurt people—to inflict pain—and is frightened at the same time. He is very deeply thinking. I do not know who these people could be. Doctors? I suppose. It could be on a ship, I do not know what it is. He might have been out shooting with pals—dreaming that he was wounded, being operated on or it could be the man whom he wounded or killed. It is a

young boy. I would not trust the boy with his expression on his lips. These are very old—wise perhaps (the doctors). That's all.

To this picture he gives the unusual interpretation that the man on the operating table is not unconscious but is feeling the pain. In the popular interpretation, namely that the boy is having a day-dream of being the surgeon, aggression is sublimated; the patient's interpretation that the boy may have killed the man on the operating table can be described as an expression of archaic aggression which aims at killing the father. In reality, as we have seen, the patient feels weak, feels he has no guts. The tone of the story was vague, dream-like and slightly confused, because he was uncertain about which character to identify himself with. Was he the boy who had inflicted the wound or was he the man who was wounded? It appears as though in the test situation he could afford to experience both parts simultaneously—that is, to inflict pain and to suffer it. In the transference he seems to give me a warning by saying, 'I would not trust the boy with his expression on his lips'.

Father and son—card 7 BM

These are no easy ones... It could be son and father. The son may be in trouble, he is confiding, the father may be helping, the son got a lot of the cares of the world on his shoulders, he is very worried. The father seems to say, well it is not so bad, so serious. But he does not think so, it is very bad, worse than might be, the sun will not shine tomorrow. I seem to feel that my mind is not free to interpret. It may be what I say here is going to reveal something. If I want a certain job, you would say with his temperament (pointing to the operation scene)—no. I do not think he killed anyone necessarily but to him it is very serious. How much he will talk—he still will feel like that.

This impressive story is surprising even if taken only at the level of its manifest content. The son confiding in the father—a son who consciously has nothing but contempt for his father. At a deeper level it appears that the story's underlying mood was one of anxiety, guilt and despair resulting from the breakthrough of the patient's aggression in the previous story when he said 'I would not trust the boy with his expression on

his lips'. Here it is the father who cannot be trusted, because he will not convey his knowledge to his son. In the operation scene, Sam felt sufficiently supported by me to let his ruthless side be revealed, but his guilt became so strong that the apparently protective father of this story turned into the father who as it were lured the son back, into the position of the small boy. In doing so the father would know also how to protect himself from the murderous impulses of his son. Thus the son feels doomed to remain the ineffective, weak boy without guts.

To maintain the continuity of the main trend of the stories the following two cards have been omitted.

The next picture is the 'Old man in a graveyard'.

Old man in a graveyard—card 15

I do not like this game...all right I will tell a fantastic story. It could be a prisoner, he seems handcuffed, he murdered a man. He is an old man, clever, he could be a negro, he is visiting the grave of the man whom he killed. He could be a religious man. He has got his hands down. I do not know what this means. He is not repenting, not sorry, he is either a religious man or a sheriff, a judge, he has done it because he had to do it, the other one was a bad man. Nevertheless, he is going to be hung—it may be. Cannot say much more.

It appears that the story is concerned with the father killing the son. With his opening remark Sam reassures himself that he may proceed to reveal the terrifying conflict of the father-son relationship. He tries to detach himself from the impact of the picture by calling the story a fantastic one. As before, the father is thought of wise, knowing and judging. However, this time Sam need not be suspicious of these qualities since his immediate perception of the old man was that of a handcuffed negro, evidently a figure of the deprived man who arouses love and contempt. The negro is the primitive man who is allowed to be subjected to strong impulses which are unacceptable to Sam. The old man's action seemed an inevitable outcome of the son's attempt to kill the father. But the feeling of doom which was conveyed in the previous story gives way to recognition that the father is not a free agent either. In Sam's words 'he (the negro) had to do it'.

The theme of father and son is followed up in the 'Hypnosis scene'.

Hypnosis scene—card 12 M

This could mean lots of things. A girl or a boy, sleeping, this could be a kind man, hypnotizing I think. It may be he is not such a kind man. He hypnotized the boy, he is now going to exert an influence on the boy, not for a good purpose I think, he wants to have things done. He wants the boy under his power. He is not a good man, he may be cunning, crafty. He is very close, it is crafty to get so close. He is a boy like me, young and boyish. With soft features. I think he is easily influenced. He got very close to him, he is kneeling. What will happen in the end? I do not think he is a psychiatrist. Unless he is an amateur psychiatrist. I do not know what will be the outcome. No, I don't know. I feel nothing will happen... my mind thinks of little things. He could be strangling him but this does not follow from what I said before. He could be sleeping peacefully. There is nothing else. I thought I had a good imagination.

The question is raised again as to whether the father is a good or a bad man. The conclusion is that he is bad—'it is crafty to get so close'. In contrast to the 'Father and son' story in which the father could not be trusted because he did not allow the son to share his knowledge, here the father aroused anxiety because he got too close. This reveals the extent to which Sam feels invaded by the tester, who wants to 'have things done'. The anxiety of being over-powered, in Sam's words being strangled by the hypnotist, breaks through after he has described the hypnotist as an amateur psychiatrist. However, as we know from the interview, Sam was called an amateur psychiatrist by his fellow patients. By using this term he reveals the degree of tension to which he is subjected from within and without. On the subject level which is unconscious he is the amateur psychiatrist. His anxiety derives from the fear of being the invader himself, a fear which he yet must project on to the object who is undoubtedly the tester.

Bedroom scene—card 13 MF

Looks as if he murdered the woman. He just murdered her. It is perhaps his wife. He does not know what to do. Oh God—my pain (touches

his back). He is a young bloke, there may be another story. He had sex with the woman, she could be a prostitute. She is asleep, he is ashamed. What would mother say? I am not a boy, a man now. She (mother) thinks I am still a boy but I must be a man. It looks very poor, like love in the dark. What is he going to do? Wondering. That is where he is—got wondering.

The most dramatic moment in the story occurred when Sam touched his back and exclaimed 'Oh, God my pain'. This happened after he had interpreted the situation following upon the murder of the woman. It seems, therefore, that his pains after the encounter with the fellow-patient, of which he spoke in the interview, did not result so much from the fear of being killed as from the fear of his aggressive feelings activated in the face of violence. In the interview Sam also mentioned his pains after having complained about being tied to his mother. It appears from the story that his wish to separate from the mother cannot be realised because separation means killing the mother. It was after having exclaimed 'Oh, God my pain' that he discontinued one story and began another one, undoing what had happened before and reverting to the status of a boy who is kept wondering whether mother will approve.

I usually ask the patient to choose the last card from the remaining pictures. This procedure, which is often a rewarding one, has been adopted from Shneidman's 'Make a Picture Story' test procedure. Sam's last story, in which the fear of coming close to people was again expressed, will be omitted.

Some brief extracts from another series of T.A.T. pictures will now be quoted as further illustrations of my argument. In addition these extracts will be used in an attempt to deal with the remaining problem raised in the introduction, that of the possible effect of the test experience on the patient.

Case 2. The next case is that of a woman in her forties, unmarried, living with her mother. Miss B was sent to me for diagnostic purposes; she was suffering from severe somatic symptoms for which no organic cause could be found. Before administering the T.A.T., I had given her the Wechsler and the Rorschach tests. Since she was not a Unit patient I had not seen her earlier.

The extracts will, in the main, be limited to

remarks which she made at the end of her stories. First, however, her story to the first card, 'Boy with violin', will be quoted.

'A boy wishing he could play the violin—or viola—but he had the feeling that he never would be able to be a first-class musician. He did not know whether it was worth trying or going on with it at all. You want the finish. I think he has made up his mind that it would be hopeless, he will have to abandon the idea and turn to something else (to what?). I gave you an ending. *You* want a serial, not a story. It would be another story to go into his future after that.'

The story bears a certain resemblance to Sam's; like Sam, who asked 'Is it worth all the effort?', she remarked that the boy did not know whether it was worth trying. She expressed the same ambivalence as Sam, but developed a stronger resistance towards the end when she would not disclose what the boy intended to turn to. The question arises: 'To what or to whom did she want to turn?' Obviously she did not trust me.

Her second story was more than twice the length of the first one. By then she was talking so quickly that she had to be asked to slow down so her stories could be recorded. To this she retorted angrily 'You put me off my stroke'. At the end of the story she remarked 'Don't want me to spoil the ending by asking. I never thought of making stories—but I got practice with you, and I don't know where I might finish up'. It seems that Miss B was stimulated by her ability to stand up to the challenge of the situation. She felt excited to find herself capable of producing something creative. However, her remark 'I don't know where I might finish up' displayed considerable anxiety lest she should be carried away. In using the words 'I got practice with you' she acknowledged the significance of my role.

The fact that the tester writes down the patient's stories in the T.A.T. is of importance. As a rule, patients are not perturbed by it, as might be expected, but they tend rather to be proud or flattered that their words are thought important enough to be preserved. However, the question of pace is an essential factor in the administration and interpretation of the test. Not many patients are sufficiently well related to the tester to adjust their flow of speech spontaneously to the tester's ability to record.

Miss B's angry remark following my request to reduce her pace expressed her unwillingness to consider the tester's personal limitations; in fact, she made an issue of this. For instance, she remarked later on: 'For once, you were quicker than I was'.

Soon afterwards, she was attacking again. She concluded the next story by saying 'She (the woman in the picture) tells him (the man) to do his damndest'. She then added sarcastically: 'Difficult to say and to spell', indicating that she was well aware of the fact that English was not my mother tongue.

However, open hostility gave way to ambivalence when she remarked after the next story: 'Sorry, that is the best I can do for you. One cannot let the spirit move for everything. I am very obliging, but I can't oblige if I can't.'

The ending of the next story indicated her increased involvement in the art of story telling, as it were, by the ironical remark 'I really think I should be paid. Anyhow, I reserve copyright'. By this she indicated that the spirit, mentioned in the previous story, was moving but had to be held in check.

However, her defences were near collapsing when she was confronted with the 'Hypnosis scene'; after her story she remarked: 'I will not reserve the copyright on that one. Nor sign or acknowledge it. I call it a very poor thing.' The extent to which she was disturbed by the test material became apparent in remarks such as: 'Don't put that in—this is not part of the story—put it in parentheses if you must have it down—sorry, I must think of something I suppose—I really can't—you take it that I am defeated'. Then suddenly 'He—(the boy)—could be crippled, he should be able to walk'. A difficulty in walking had been one of her symptoms.

The story she gave to the 'Bedroom Scene' showed her again in full command of her defence mechanisms. The tone and content of the story were ironical throughout. To quote: 'My God, what have I done. He is dead. He sat down on the table putting his head down. What have I done, what have I done.' Later, the thought entered the man's mind that she might not be dead. 'He turned to look, she slowly sat up, and started her running him down in her usual manner. He turned from her in disgust, out of the room, out of her life, forever.'

The next story was a long and significant one.

She remarked at the end: 'I am not going to spoil the ending by adding anything to it—it is a nice ending. Don't put that in. I don't trust you—you will mix sugar with sand, that is an English colloquialism which you probably don't know.'

By referring once more to my prompting and questioning at the end of the first story she showed the anxiety and resentment which it had caused. The assumption of my ignorance of the 'sugar and sand' phrase hit again at my imperfect English. Her remark on 'spoiling', namely, spoiling the ending, was in some way a repetition of what she had said before. Its meaning, however, became more intelligible now. In this instance, her remark linked up with her story where a woman did not want to spoil the immaculate whiteness of the snow. This gave me the impression that her story dealt with problems of being a virgin. The correctness of this interpretation was confirmed by a remark to her doctor in which she prided herself upon being a virgin.

Miss B felt threatened that her phantasies and secret thoughts might be interfered with. With her exclamation 'I don't trust you' she made a violent attempt to defend herself from experiencing something that was both terrifying and desirable.

Her story to the card which she chose herself dealt with a couple's quarrel and its outcome. She then said, 'You want to know what happened afterwards'. Three years later they were on a farm. The man did make good (as he had promised to do in her story) but the woman sometimes wondered 'if she considered it worth the drudgery and ceaseless round of toil'. Eventually she decided that all things have to be paid for, and that it was worth it, after all. True to form Miss B added 'a complete film for you—everything the audience could desire'.

There is, no doubt, a striking contrast between the last story and the preceding ones. Not only did Miss B volunteer to supplement her story ('you want to know what happened afterwards?'), but also its content and tone were decisively different from those of the previous stories. It was affirmative, constructive, and in some ways mature.

It seems justifiable to consider the last story as a symbolization of the experience she had had through the test situation. The quarrel of the couple corresponded to the struggle she had fought with me. The bickering woman of the

'Bedroom scene' who chased the man away represented herself attempting to protect herself from me. She had to defend herself against having her stories spoiled by me which was like defending her virginity. The fact that I neither retaliated nor rebuked her made it possible for her to drop her defences. Knowing that the card which she chose herself was the last one, she could afford to make amends like the man in her story. She also knew that reconciliation meant 'ceaseless toil'. She thus revealed what a painful effort it meant to her to allow me to catch a glimpse of her inner values.

It is unfortunately difficult to answer the question what after-effects such and similar experiences have on the patient.

As we have seen, the test situation may permit the tester to gain insight into the patient's potentialities for working through his problems. However, the actual working through can only be achieved through the repetition of experiences such as are evoked in the test situation. As a rule, I give interpretations only as far as they are needed for a successful continuation of the test. Besides, the principle of timing interpretations applies as much to this situation as to a therapeutic setting. Moreover, it has been found that in the majority of cases the patient's experience of the test situation will remain an isolated one,

but despite this, it is difficult to imagine that there will be no inner repercussions.

Before concluding I wish to refer once more to Bernstein's study, in which it was found that the presence of the tester acted as an inhibitory factor for strongly emotional material. If the tester is understood as one who brings the patient's defences into operation, Bernstein's experiment would confirm that this is one significant aspect of the tester's role. It is through the interplay of emotions and defences that a genuine picture of the dynamics underlying the patient's psychopathology can be obtained.

The case material presented here may be more rich, impressive, or sparkling than that of other patients, but it is characteristic of and consistent with phenomena which I have recorded over a number of years. This has led me to the conclusion that the patient's experience of the test situation is characterized by its transpersonal rather than by its personal nature.

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A further study of the predictive validity of a psychological test of brain damage*

By D. WALTON† AND M. D. MATHER

A recent study (Walton & Black, 1957; Walton, 1958*a*) reported the validity of a new learning test (The Modified Word-Learning Test) for diagnosing organic brain damage. Important differences were demonstrated on this test between a group of 223 co-operative non-brain-damaged psychiatric patients and normal controls, and a group of forty-six brain-damaged patients. In an effort to cross-validate these findings a further study involving 304 subjects was undertaken (Walton, White, Black & Young, 1959; Walton & White, 1959). The major conclusions of the validation study were confirmed. Two studies also tentatively demonstrated the predictive validity of the test when applied to patients suffering from psychiatric disorders of the senium (Walton, 1958*b, c*). Inglis (1959) reanalysed some of the test results from one of these studies (Walton, 1958*c*) with respect to outcome of illness. He used two broad classes of outcome—favourable and unfavourable. For example, he regarded 're-graded voluntary, bright, cheerful and correctly orientated', as a favourable outcome, whereas 'Died, cardiovascular degeneration', as unfavourable. The patients were then classified in terms of test scores, that is either 'high' or 'low'. He found a significant relationship between test score and outcome which he did not find when he compared outcome and initial diagnosis. He concluded that scores on the M.W.-L.T. could be used to predict outcome of psychiatric illness of the senium better than initial diagnosis.

In order to confirm the apparent predictive validity of the M.W.-L.T. a further study was undertaken (Walton & Black, 1959). The results were sufficiently encouraging as to suggest that the test could be used tentatively in a predictive context.

The aim of the present study was to confirm once more the predictive validity of the test and to establish more certainly its independent

diagnostic contribution in the clinically doubtful case of brain damage.

METHOD

Fifty-one patients were referred to the psychology department in order that the psychologist should give an opinion with regard to the presence or absence of brain damage. The M.W.-L.T. was administered to each patient. The test results were not examined in relation to diagnosis until the psychiatrist had reached a firm diagnostic decision. When this had been done the two authors independently of each other examined the case-notes of each of the patients to determine whether the psychiatrist could independently justify his diagnosis. A diagnosis of brain damage was acceptable only if either certain confirmatory criteria or additional criteria were applicable to the case and that each psychologist independently of the other had reached the same conclusion with respect to which of the signs applied to a particular case. The three confirmatory criteria were:

- (1) Neuro-surgery having demonstrated brain damage.
- (2) Laboratory tests having confirmed the presence of brain damage, for example, G.P.I.
- (3) Evidence of unequivocal cerebral damage following head injury.

It was also considered that additional, wider criteria were required in order to provide a more comprehensive check on the presence of organicity and to obviate the possibility of a spuriously high test validity (the psychiatric and psychological criteria of diagnosis may have overlapped). These eight additional criteria were applied to those cases where unequivocal criteria of the type listed above were not available. These criteria were unrelated to cognitive or memory function (Shapiro, Post, Lofving & Inglis, 1956). The signs were:

- (1) Cerebral incidents or attacks (a history strongly suggestive of focal cerebral disorder, including fits, transitional paresis and the like).
- (2) Confusional episodes (episodes of abnormal

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behaviour and psychotic experiences in a setting of disorientation).

(3) Incontinence, except if occurring only at the height of the illness.

(4) Character change, such as deterioration of personal habits and caricaturing of previous personality traits: e.g. increased pre-occupation with money, health and so on.

(5) Confirmed neurological signs or symptoms, including aphasia.

(6) Perplexity (an impression or complaint of bewilderment or puzzlement).

(7) Grossly abnormal E.E.G.

(8) Presentation of a clinical picture not clearly belonging to one of the recognized 'functional' psychiatric syndromes, e.g. 'depression with schizophrenic symptoms and visual hallucinations'.

If none of these two sets of criteria applied, yet the diagnosis was of brain damage, that patient was omitted because of the possibility that the psychological test results had influenced the psychiatrist in reaching his diagnosis. On the other hand, a diagnosis of not brain damaged was

Using the optimum cut-off point of twenty-six established by previous investigations none of the seven neurotics were misclassified. Two of the four functional psychotics were correctly identified.

It can be seen that there are three separate groups of brain-damaged patients. In group one there are eight epileptics. Five of these either showed E.E.G. abnormality in the left temporal lobe (dominant hemisphere) and as a result of this a temporal lobectomy was performed or had damage in the left temporal lobe (dominant hemisphere). All obtained scores within the brain-damaged range. One epileptic showed an abnormal focus in the right temporal lobe (non-dominant hemisphere). He behaved on the test as a non-brain-damaged person. One of the epileptics is not included in the table. His E.E.G. record was abnormal, showing a left-sided abnormality (dominant hemisphere) which was becoming epileptogenic. He had had three full presentations of the words and had failed to learn the meanings of any of them. He had a catastrophic reaction to the testing at this point, testing having therefore to be discontinued. The aetiology

Table 1. *Distribution of M.W.-L.T. scores for each of the final diagnostic groups*

M.W.- L.T. scores	Dysthymics	Mixed neurotics	Hysterics	Psychotic depressives	Schizo- phrenics	Epileptics	Organics (generalized cortical damage)	Organics (localized lesions)
1-5	1	.	.	.	.	.	1	1
6-10	3	.	.	.	.	1	.	1
11-15	1	.	.	1	.	.	.	.
16-20	.	.	.	.	.	.	1	.
21-25	.	.	.	.	1	1	.	.
26-30	.	.	.	.	1	2	6	.
31-35	.	.	.	1	.	2	9	3
36-40	.	.	.	.	.	.	.	.
Over 40	.	.	.	.	.	1	.	.
N = 41	5	1	1	2	2	7*	17	5

* One patient was not included here, owing to a catastrophic reaction testing having to be discontinued.

accepted only when none of the confirmatory and additional criteria were applicable.

Ten cases were rejected because the diagnosis was still in doubt or had not been reached by means of criteria which were independent of functions measured by the M.W.-L.T. or because there was disagreement between the raters with regard to the applicability of certain signs to certain patients.

RESULTS

Table 1 shows the distribution of M.W.-L.T. scores for each of the final diagnostic groups.

of the remaining epileptic was non-specific. Thus all those dominant epileptics failed to learn to the test's required criterion, whilst the epileptic with abnormality in the non-dominant temporal lobe did learn. These results are fully consistent with those of Meyer & Yates (1955), and Meyer (1959).

Of the seventeen patients diagnosed as suffering from generalised cortical damage, e.g. senile dementia, cerebral arteriosclerosis, G.P.I., or disseminated sclerosis, fifteen (88%) were correctly identified. Three of the five patients with localized brain lesions were identified correctly.

Thus of the heterogeneous group of thirty organics, twenty-four were correctly identified. The percentage of correct test diagnoses obviously varies considerably with the type of organic condition, a conclusion consistent with the findings of the cross-validation study (Walton *et al.* 1959). The same conclusion can be reached from an examination of the results from the two previous predictive studies and the present one all using the M.W.-L.T. (Table 2).

Table 2. *Percentage of correct diagnoses in the three predictive studies using a critical cut-off point of twenty-six.*

Study	All cases included in the study	All cases included in the study except those organics with localized damage
1958	93	93
1959	82	92
1960	80	86

The test thus consistently shows a high predictive validity, though it is also apparent that the extent of this validity depends on the percentage of patients included in the organic sample who might be considered to be suffering from generalized organic brain damage. Very high predictive test validity has been demonstrated on three occasions when localized organics have been excluded.

Finally, it ought to be pointed out that thirteen of the thirty organics, in the present sample,

although returning brain-damaged scores, had also failed to learn to the test's required criterion. Four of these patients had failed to learn the definitions of any of the words, five had learned the meaning of one word, two had learned the meanings of only two words, and two had learned the meanings of only four words. Obviously if testing had been continued their M.W.-L.T. scores would have been much higher than those recorded. Ten of these thirteen patients were suffering from generalized cortical pathology.

SUMMARY

The present experiment was carried out to provide further evidence of the predictive validity of the M.W.-L.T. The test was administered to fifty-one patients referred to the psychologist for an opinion as to the presence or absence of brain damage. The test results were not examined in relation to diagnosis until the psychiatrist had reached a firm diagnostic decision or until these diagnostic decisions had been verified against two additional sets of criteria assessed independently of each other by the authors. Ten cases were rejected from the study because they did not satisfy these criteria.

The test was again shown to have a high predictive validity especially with respect to the differentiation of the non-brain-damaged psychiatric patient from the patient suffering from generalized organic pathology.

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Proceedings of the Medical Section of the British Psychological Society

304. 28 October 1959. Dr M. FORDHAM and Dr P. HEIMANN: Symposium on Countertransference, I.
305. 25 November 1959. Dr D. W. WINNICOTT, Dr M. LITTLE and Mrs R. STRAUSS: Symposium on Countertransference, II.
306. 9 December 1959. Mr F. H. STRAUSS: Analytic Implications of the Test Situation.
307. 27 January 1960. Dr MURRAY JACKSON: Jung's 'Archtype': Clarity or Confusion? (Address from the Chair).
308. 24 February 1960. Miss NORAH GIBBS and Mrs JESSIE WILLIAMS: Problems observed in children with Cerebral Palsy.
309. 23 March 1960. Mr R. MONEY-KYRLE and Dr MARIE JAHODA: Symposium on Prejudice (jointly with the Social Psychology Section).
310. 27 April 1960. Dr ELLIOTT JAQUES: Psychic Equilibrium, Psychotic Anxieties and the Sense of Justice.
311. 25 May 1960. Dr S. H. FOULKES: Group Processes and the Individual in the Therapeutic Group.
312. 8 June 1960. Dr BRUNO KLOPPER: The Rorschach Method in Research on the Psychological Effects of Hallucinogens.
313. 26 October 1960. Dr JOHN BOWLBY: Processes of Mourning.
314. 23 November 1960. Dr JAMES M. DAVIE and Dr THOMAS FREEMAN: The Non-Psychotic Residue in Schizophrenia.
315. 14 December 1960. Dr ILSE HELLMAN, Dr DUGMORE HUNTER and Dr A. PLAUT: Symposium: Technical Problems in the Treatment of Adolescents.

Reviews

The Divided Self. By R. D. LAING. (Pp. 240. 25s.) London: Tavistock Publications. 1960.

Dr Laing's book has had a timely arrival. For some years there has been a growing demand for information on the application of existentialist philosophy to psychiatry and allied disciplines. Quite recently an attempt was made to meet this demand by May, Angel and Ellenberger in their book *Existence*. Dr Laing's book provides an additional volume for those who wish to acquaint themselves with this movement in psychiatry and psychology. In the preface the author states that his approach is not directly based on any established existential philosophy. Nevertheless, its roots are embedded in this philosophical tradition and the work is, as he says, a study in existential psychiatry with special reference to 'schizoid and schizophrenic persons'.

The first part of the book provides an introduction. Chapters I and II not only present and explain a number of concepts which will be new to most psychiatrists, but they also introduce the reader to the manner in which existentialist phenomenology regards contemporary clinical psychiatry and psychopathology. In Chapter III there is a general account of how existentialist phenomenology interprets the phenomena of mental health and mental illness. The central feature of his interpretation is the concept of the individual's whole experience of being—his existential position. Existentialist psychiatry is primarily concerned with the patient's existential position—the manner in which he regards his being in its every conceivable aspect and relationship. The healthy are differentiated from the sick and the potentially sick by the degree to which they experience their existence as an indivisible unity harmoniously integrated with the environment of objects. The former are described as being in an existential position of primary ontological security while the latter are described as being in an existential position of ontological insecurity. The ontologically insecure person is uncertain of his existence and of the relationship of his being to others. He dreads the impact of the latter upon his fragmented sense of being. Three

forms of anxiety spring from ontological insecurity—they are described as engulfment, implosion and petrification. In all three the danger consists of a threat to the identity of self. Individuals become terrifyingly frightening for the ontologically insecure person. He must, therefore, undertake every kind of manoeuvre—both intellectual and physical—to avoid the danger of the loss of the self.

The second and third parts of the book describe in detail the sequence of events which lead to the schizoid state and to schizophrenia in certain ontologically insecure individuals. Lack of basic unity predisposes such individuals to a split between body and mind. The self, terrified of annihilation, is divorced from the body. The body now becomes an object like any other. The body becomes the centre of a false self. The attitude of the 'inner' or 'true' self to the body may range from sympathy to hate. Relations with the environment are undertaken by the false self system while the true self is hidden from sight. No means of communication exists between the two systems. In the schizoid state the false self is completely subservient to the wishes of those it is in contact with and there is a concurrent trend towards the adoption of the traits of character of those it wishes to please. Crises occur when the true self becomes suffused with hatred of the false self. The illness known as schizophrenia will appear whenever the influence of the false self—felt as dead, unreal and empty—penetrates the true self. The latter becomes volatilized and fragmented. It is impoverished and filled with hate. Meanwhile the false self attains a new ontology and becomes even more dead, unreal and mechanical. According to Dr Laing the schizophrenic feels he has killed his self in order to avoid being killed. Nevertheless, the self may continue an unembodied existence as a kind of ghost. Within this framework every clinical manifestation of schizophrenia can be accommodated and interpreted.

Dr Laing is both a phenomenologist and an exponent of existentialist psychiatry. On this account he must eschew theorizing and confine himself to a detailed description of clinical phenomena and to an account of the patient's existential posi-

tion. In this approach there is no room for speculation about unconscious mental conflicts. Perhaps unwittingly Dr Laing has been unable to conform to the discipline of existentialist phenomenology if indeed such a conformity is possible. His presentation can only be described as a mixture of description and interpretation. Inspection of the clinical data does not reveal any new or unusual phenomena. The content of the communications will be familiar to all experienced psychiatrists. They will, however, find it difficult to place the phenomena reported by the non-schizophrenic (schizoid) patients, because this data is so widespread in both the psychoneuroses and the character disorders. It can be elicited in almost every patient as an aspect of their conscious conflict. The psychoanalyst will hardly be satisfied with this preoccupation with conscious experience. He will suspect, in spite of Dr Laing's assertion, that psychoanalysis provides an escape from existential dangers, that the fears expressed are principally the result of unconscious homosexual wishes.

In common with most authors whose main experience is with the neuroses and character disorders Dr Laing has committed himself to a theory of schizophrenia which is indistinguishable from that of the neuroses. His model is a structural one in which endopsychic structures struggle with one another under the headings of true self, false self and their split off derivatives which are, in turn, in conflict. This is all very reminiscent of Melanie Klein's theory of internal objects. It is no surprise therefore to find that the psychoanalytic concepts of conflict and defence are freely employed as a means of explaining the clinical phenomena. The psychiatric reader will no doubt reflect that as yet there is no conclusive evidence that mental conflict plays more than a precipitating role in schizophrenic reactions.

If Dr Laing had confined himself, as no doubt he intended to do, to a strictly existentialist phenomenological account of certain psychiatric syndromes, his presentation would have been welcomed by all as an addition to our literature. Unfortunately, he decided to widen the scope of his discourse to point out that the concepts of clinical psychiatry, and Freud's psychoanalysis are inadequate for the task of understanding the nature of the mental disturbance and for appreciating the patients' unhappy state. This is a claim for which there is not the slightest justification. Apart from the terminology there is nothing in

Dr Laing's presentation which is not recognized daily by the practising psychoanalyst.

It may be that existentialist phenomenology has a contribution to make to psychiatry, but it is doubtful if this book will provide the necessary bridgehead for the advance of knowledge which is so eagerly awaited by all engaged in the study and treatment of the mentally ill.

THOMAS FREEMAN

Communication or Conflict. Edited by MARY CAPES. (Pp. 228. 30s.) London: Tavistock Publications. 1960.

One of the encouraging differences between the intellectual life of the pre- and post-war worlds is the vast increase in the number of conferences, and especially international conferences. But an even more encouraging sign of progress is that conference planners should be interested in trying to find ways of making better conferences. A multinational conference on conferences, convened by the World Federation for Mental Health, financially sponsored by the Josiah Macy Jr. Foundation and attended by such people as Delafresnaye, Fremont-Smith, Kelber, Klineberg, Mead and Wilson (both A.T.M. and Roger)—to select vividly from twenty-one distinguished conference goers—is something worth reporting.

Those interested in trying to facilitate communication within any kind of group will find this an exhilarating book. It deals realistically with many intangibles, the sort of things that we can recognize as influencing groups as soon as they are said, but even if we knew them before, knew them only ineffectively, and did not act as though we knew them. Summer or winter, single rooms or dormitories, pinstripes or shirtsleeves, paying yourself or being paid for, simultaneous or consecutive translations, the need in multinational meetings for interpreters of the mores as well as of the language—these are examples of the kind of things that people who take part in groups ought to worry about.

Those of us who, in addition, are trying to find ways of communicating what was communicated in a group to those who were not there (and to those who were there) will find much to marvel at in the structure of the book, and especially in the way the substance of the discussions is presented. Weighing less than one pound and costing only one and a half, it contains the distillate of seven

days' worth of brilliant conversation preserved with no taste of the can at all, three nourishing pre-conference papers and five snappy little presents to be taken home at the end of what was obviously a gorgeous party.

The working papers covered 'Cultural perspective', 'The appreciation of individual idiosyncracies' and 'The historical development of group work'. Each is a scholarly and stimulating review of material drawn from very wide fields and relevant to the main theme of the conference, the psychological, cultural, ideological and semantic factors affecting conference operation. These papers were made available to the conference members before the meeting. There follows the substance of fourteen discussions which took place in seven days at Eastbourne. This is presented with elegant economy and plenty of sparkle still left. The toil that achieved this does not bear thinking of, but the editor seems to put even this in its place. 'In Part II the relevant discussion... has been collated under appropriate subtitles and, it should be stated, not in chronological order', she says, as though it took no time at all. (Second to the inappropriate inhospitality of the weather—'snow and icy conditions prevailed'—this implied understatement must be the most English thing about the conference.) The discussions are grouped into threes or fours, each with a terse introduction, and the themes were as follows. Goals, Preconference Planning, Organization, Group Atmosphere, Agenda Formation, Small Groups and Plenary Sessions, Manipulation, Steering Committee, Leadership, The Emergent Leader, Communication, Evaluation, Training in Organization, and Research. Each page bristles with texts—'An artificial language is unsatisfactory for the creativity of thinking, because it has no cultural background'; 'A sanctioned relationship must be established'; 'The Conference design should make available certain time for private conversation'; 'If you are not running a therapeutic conference, stay on the level on which the conference was called'; 'If there is one thing worse than ignoring psychiatric factors it is to ignore physical ones'.

The third part contains five appendices. In the first (distillate of distillates) is summarized, in question form, the central issues discussed in the book. This (addressed to sponsors and office holders) will be of the greatest practical value to any concerned with arranging meetings, as will the

other four appendices on different kinds of small conferences.

Conferences can be a bore, but this one was not. Gratitude goes to the participants for so energetically burning the candle at both ends, and to Mary Capes whose bookmaking enables so many more to enjoy its lovely light and with it to explore what 'lies hidden in the golden hills of conference research'.

M. L. JOHNSON ABERCROMBIE

Search for Security. By M. J. FIELD. (Pp. 478. 42s.) London: Faber and Faber. 1960.

Dr Margaret Field is a remarkable person. She is in the tradition of the great English Characters, women of the stamp of Freya Stark who dominate savage tribesmen with an umbrella and a wide-brimmed hat. She has had a lifelong affair with that region of West Africa which has now become the state of Ghana.

Dr Field's early studies in this region were in the field of cultural anthropology, giving rise to a monograph, in 1937, on *Religion and Medicine of the Ga People*. She became particularly interested in the beliefs and practices centred upon the numerous shrines in villages in the bush, where priests would become possessed by the spirit of a minor god and so empowered to practise divination, exorcism and healing. From her observations of the work of these rustic shamans, Dr Field became convinced that the essence of their therapy lay in their recognition and treatment of the anxieties, depressions and other psychiatric manifestations presented by their patients.

Such is her pertinacity that, quite late in her medical career, she returned to a teaching hospital to learn psychiatry in order to go out again to Ghana to carry out the present study.

It must reluctantly be confessed that in spite of her evident involvement in the life of this people, the author does not altogether succeed in conveying either a systematic account of their heterogeneous society nor a convincing appraisal of the psychopathology of the patients whom she describes. Of her own convictions, one is not left in doubt; but to her ardent spirit considerations of scientific verification are clearly alien.

If the work has, in consequence, certain deficiencies as an objective analysis of phenomena such as accusations of witchcraft and exorcism, it is nevertheless of value for its vivid descriptions of

spirit-possession, and similar states of dissociation. As Georges Balandier, in *Afrique Ambigue*, has already done for the adjacent French-speaking territories, Dr Field has drawn attention to the recent widespread growth of shamanistic cults. Both authors interpret this as a consequence of rapid and unsettling acculturation, and in so doing they have indicated a fruitful area for further systematic research.

G. M. CARSTAIRS

Psychiatric Dictionary (third edition). By LELAND HINSIE and ROBERT JEAN CAMPBELL. (Pp. 788. £7.) New York: Oxford University Press. 1960.

Words are essential tools of those who labour in the field of psychiatry. They signify, as in all scientific work, concepts which tend to be involved and complex, sometimes of limited precision, and often difficult to grasp; but words are always at the mercy of the rust of history, so that their edges tend in time to become blunted or ragged. Our terms are always in danger of having to perform added tasks for which they were not first fashioned, of losing their original fineness, of having violence done them by local usages, of becoming debased and cheapened by overwork and the familiarity which breeds contempt, until many exact concepts for which a new word was once coined can no longer be surely represented by it. This cannot be laid only at the door of the laymen or the half-tutored. None of us is without responsibility for so stretching and smudging original meanings that discourse among our fellows becomes difficult because of the various use of words. One result is that we have regularly to sort out our argument to make sure if apparent agreements or disagreements truly exist.

To some extent this is inevitable. Language like science itself is a living and developing human product. The steady differentiation and extension of concepts go hand in hand with their marriage and synthesis and the creation of subsidiary concepts, and we cannot but meanwhile use what language we have so long as it is useful. Only when we arrive at the certainty that exactness demands the creation of a new term do we seek for one. We have few concepts which can be expressed as theorems or formulae, and have to anchor our concepts to words, but we must take notice whenever this anchor is dragging.

Workers in psychiatry have long needed a collection of authoritative definitions, and it is proper to hope that some day an attempt will be made at one, so that we may all speak and write about our subject certain of being understood no matter where we hail from. This dictionary, by its sweep and erudition first raises and then dashes hopes that we need seek no farther. It is a failure, but a bold and creditable one, even a half success. In truth 'no psychiatrist or psychologist ought to be without a copy', but for all its original definitions and scholarship, for all its comments and industry, it will not fully satisfy. This reviewer found it exciting and challenging and he spent happy hours with it—and will do again—but he had often to shake his British head at the North American parochialism which proudly distorts or omits some of his favourite terms. Are there no Internal Objects in the United States? Are Internalization processes taboo there? If that great woman Frieda Fromm-Reichmann is so properly mentioned is there no place for Ella Sharpe whose works are so often quoted herein as a final defining authority? A first glance raises such not-altogether patriotic but international questions and (for it is a fascinating work) closer scrutiny many more. Even local American boys do not always make good. Poor Federn! His important concept of Ego-feeling is not listed. Poor Lewin! The book is asleep to his Dream-screen.

The amount of explanation offered for various terms varies curiously—(Character Defense, for instance, gets shrift too short for so elaborate a subject, whereas Super Ego is adequately covered)—but this book offers thousands of unassailable definitions, to be found easily nowhere else, and it brings authority and clarity within its covers for the working psychiatrist. It is a significant attempt towards ordering semantic confusion. It offers—whatever its defects of imbalance, omission and parochialism—fixed definitions which many a reader will use with confidence. It never misleads although it may leave one undernourished.

The task the authors set themselves is perhaps impossibly difficult, but it is noble. They show by their mettle that they could do better, and certainly as the years and editions go by this dictionary could become a standard work. At present it is only a very useful book.

The volume is beautifully produced, clearly printed and on good paper; but the price is high.

T. F. MAIN

Proceedings of the First International Congress of Neurological Sciences. Volume 3. Electroencephalography, Clinical Neurophysiology and Epilepsy. Edited by LUDO VAN BOGAERT and J. RADERMECKER. (Pp. 707. £7.) London: Pergamon Press. 1959.

This is Volume 3 of the Proceedings of the First International Congress of Neurological Sciences, and the first to be published of the five volumes which will cover the entire Proceedings. It contains the 135 papers presented at the Fourth International Congress of Electroencephalography and Clinical Neurophysiology and the Eighth Reunion of the International League against Epilepsy.

The authors are internationally known experts who, with their equally famous colleagues in other branches of the neurological sciences, were brought together at a Congress held in Brussels. This volume gives up-to-date reviews and information on the three subjects.

American Handbook of Psychiatry. Volumes 1 and 2. Edited by SILVANO ARIETI. (Pp. 2098. \$25.00.) New York: Basic Books. 1959.

These two monumental volumes attempt to encompass not only the present state of psychiatric knowledge, but related fields as well. In a useful form, 111 authors present the developments, concepts, trends, techniques, problems and prospects of psychiatry today, and most major schools of thought and approaches are included. A multiple, diversified, approach has been taken rather than an attempt to provide a synthesis of divergent points of view.

The handbook is divided into fifteen parts as follows: General, The Psychoneuroses and Allied Conditions, The Functional Psychoses, Psychopathic Conditions (together with Deviations and Addictions), Psychosomatic Medicine, Childhood and Adolescence, Language and Communication, Organic Conditions, The Psychotherapies, Psychoanalytic Therapies, The Physical Therapies, Relations with Basic Sciences and Experimental Psychiatry, Contribution from Related Fields, Management and Care of the Patient, and Legal, Administrative, Didactical and Preventive Psychiatry.

Effect of Small Doses of Alcohol on a Skill Resembling Driving. By G. C. DREW, W. P. COLQUHOUN, and HAZEL A. LONG. (Pp. 108. 7s. 6d.) London: H.M. Stationery Office. 1959.

This study was designed to investigate the effects of small amounts of alcohol which would produce concentrations in the blood below those regarded in a number of countries as evidence of intoxication, and within the ranges reached in ordinary social drinking. The subjects undertook in the laboratory a series of tests on an experimental task which in a simplified form resembled driving a vehicle on the road.

The findings show that performance generally begins to deteriorate with very low blood alcohol levels, and that deterioration progresses as the blood alcohol level rises. There is a wide variation between different individuals and about a quarter of the subjects tested showed reduced error after alcohol. The authors have made some attempt to assess the importance of various personal factors which may account for these individual differences. The main finding is, however, that a high proportion of individuals show a measurable impairment in performance after drinking amounts of alcohol too small to produce even those clinical signs of intoxication apparent to trained observers.

Medicine and the Other Disciplines. Edited by IAGO GALDSTON. (Pp. 192. \$3.00.) New York: International Universities Press. 1960.

This volume contains a series of ten lectures by eminent men in a number of fields, elaborating, from the point of view of each discipline, the effects of the changing outlook of science on the field of medicine and on the reciprocal relation between medicine and other disciplines. The contributors include Ernest Nagel, Norbert Weiner, Benjamin Paul, David Peck, Jules Masserman, Theodore Shedlovsky, Clarence Oberndorf, D. Ewen Cameron, Aldwyn Stokes and Charles Glen King.

Parent Guidance in the Nursery School. By MARGARETE RUBEN. (Pp. 72. \$2.00.) New York: International Universities Press. 1960.

This small handbook, written by a psychoanalyst, deals with such problems as thumb-sucking, eating and toilet training, aggression,

timidity, masturbation, sleep disturbances and jealousy. Chapters are included on the techniques and limitations of counselling. The book is written in a non-technical form, and is the outcome of the author's teaching experience with a seminar for nursery school directors and teachers.

Institutional Neurosis. By RUSSELL BARTON. (Pp. 56. 8s. 6d.) Bristol: John Wright. 1959.

The purpose of this booklet is to present in a systematic form the dreadful mental changes that may result from institutional life and the steps that can be taken to cure them. Institutional neurosis is compared with 'mental bedsores', and is described as a disease characterized by apathy, lack of initiative, loss of interest especially in things of an impersonal nature, submissiveness, apparent inability to make plans for the future, lack of individuality, and sometimes a characteristic posture and gait.

The differential diagnosis, with particular reference to schizophrenia, is discussed, as well as the relationship of the institutional neurosis to organic conditions.

Alcoholism—an Interdisciplinary Approach. Edited by DAVID PITTMAN. (Pp. 96. 30s.) Springfield: Charles C. Thomas; Oxford: Blackwell. 1959.

This report of a conference was conceived to serve at least two purposes: it is a statement of the present status of knowledge about the appearance and course of alcoholism in communities, and also is intended to provide a platform from which the research scientist can launch further investigations of this phenomenon. The first section contains five original papers, and the second includes papers prepared by interdisciplinary teams, suggesting new perspectives in alcoholism research.

Space and Sight. By M. VON SENDEN (Pp. 348. 42s.) London: Methuen. 1960.

This book is the English version of a German work published some years ago. It has new bibliographical material and an appendix containing essays by Professor A. Riesen, Mr G. J. Warnock and Professor J. Z. Young, on the implications of the material to their respective fields of psychology, philosophy and physiology. The material studied

consists of the experiences of patients born blind, or blinded in early childhood, and who have later recovered their sight. The problems of whether the congenitally blind have any true awareness of space and whether the newly sighted can recognize the visual shapes of objects previously known to them only by touch are investigated and discussed.

The Problems Arising from the Teaching of Personality Development. Edited by PAUL HALMOS. The Sociological Review Monograph No. 2. (Pp. 149. 12s.) Keele: University of North Staffordshire. 1959.

This second monograph is in effect a continuation of the discussions published in monograph no. 1. The papers in the second volume are concerned more with practical matters than the theoretical papers in volume 1, and include a discussion of students' attitudes, the training of teachers and social workers, and the role of teacher and pupil. There is also a discussion on insight, on the role of identification in teaching methods, and the teaching of personality development to experienced teachers.

Psychiatry in the Medical Specialties. By FLANDERS DUNBAR. (Pp. 535. 93s.) London: McGraw-Hill. 1959.

This book is designed to acquaint each medical specialist with the psychiatric problems likely to be encountered in his consulting room. An attempt is also made to acquaint the psychiatrist with the diagnostic problems of general medicine. New material about the relationship between endocrinology and psychiatry is included. Emphasis is placed on problems of differential diagnosis and the recognition of the patient under stress. Dr Dunbar first discusses the changing concepts of disease, then the history of the patient, his illness, the illness syndromes, and therapy.

Scoring Human Motives. By JOHN DOLLARD and FRANK AULD, Jr. (Pp. 452. 76s.) London: Oxford University Press; U.S.A.: Yale University Press. 1960.

This book presents a method for studying the psychotherapeutic process, designed to measure growth, change and progression within the patient,

and the evolution of the relationship between patient and therapist. It gives instructions for coding each 'unit' (usually a sentence) of a psychotherapeutic interview, ascribing to each unit the conscious or unconscious motivation behind it, such as 'anxiety', 'hostility' (in the case of the patient), or 'demand' and 'interpretation' (in the case of the therapist). Material is thus made accessible for scientific analysis. Sound recordings from actual cases have been transcribed.

Culture and Mental Health. Edited by MARVIN K. OPLER. (Pp. 533. 61s.) New York: Macmillan. 1960.

Dr Opler has selected a number of recent cross-cultural studies from the work of Margaret Mead, Abram Kardiner, and twenty other distinguished researchers, together with two papers of his own. The compendium attempts to show the effects of cultural patterns on mental health in world wide perspective. It features material from every continent or island area in which notable work has been done.

Epidemiological Methods in the Study of Mental Disorders. By D. D. REID. (Pp. 79. 2s. 6d.) Geneva: World Health Organization. 1960.

This short study was prepared as an introduction to ideas and methods of epidemiological inquiry that may prove useful in the study of mental disorder. Its aim is to present the general principles of the epidemiological approach in medicine and to point out both its potential and the practical limitations inherent in its application in psychiatry.

Delinquency and Parental Pathology. By ROBERT G. ANDRY. (Pp. 173. 21s.) London: Methuen. 1960.

The author has examined the widely accepted notion that material deprivation is a major cause of delinquency in children. He feels that the role played by the father has so far been ignored by investigators. Dr Andry has used an interview questionnaire in his experiments, and has tested a number of hypotheses by statistical methods. His results show that delinquency is related not only to disturbed maternal patterns but to paternal ones as well.

Memory and Hypnotic Age Regression. By ROBERT REIFF and MARTIN SCHEERER. (Pp. 253. \$5). New York: International Universities Press. 1959.

Whereas most studies of memory concern themselves with remembering specific contents and events in a person's life, this work is concerned with a person's memory of his early childhood ways of functioning. The authors present one of the first scientific investigations of this phenomenon of memory. The loss of the memory of much earlier functioning as well as its recovery, such as the clinician often sees in his patients in treatment, is explained by a theoretical framework based on Gestalt and psychoanalytical concepts.

The authors have taken some of Piaget's ingenious experiments with children, as well as some tests of earlier levels of functioning which they have devised themselves, and given these to adults hypnotically regressed to the ages of ten, seven and four years. A control group who simulated these ages was also given the tests.

On Shame and the Search for Identity. By HELEN MERRELL LYND. (Pp. 318. 25s.) London: Routledge and Kegan Paul Ltd. 1960.

Drawing upon literary as well as scientific sources, Mrs Lynd explores in this volume the nature and significance of shame and its relation to guilt. She suggests that by confronting the painful experience of shame the individual may gain a deeper understanding of himself and of his relation to other individuals and to the society in which he lives. Mrs Lynd goes on to discuss the question of identity, which has special urgency in times of swift change such as the present, and suggests that much of the contemporary study of personality is so oriented in its assumption and its methods as to divert attention from the search for identity.

Adolescent Aggression. By ALBERT BANDURA and RICHARD WALTERS. (Pp. 475. \$7.50.) New York: Ronald Press Company. 1959.

The study reported here is an attempt to identify scientifically the child-rearing factors and intra-family relationships that lead to the development of antisocial aggressive behaviour in adolescent boys. Breaking away from the more usual socio-

legal or psychoanalytic approaches, the book represents a new application of the theoretical framework and methodology used by Robert R. Sears and his collaborators in studies of nursery-school children.

On the Threshold of Delinquency. By JOHN BARRON MAYS. (Pp. 243. 25s.) Liverpool: University Press. 1959.

This work, from the Department of Social Science at the University of Liverpool, reports a piece of operational research with young delinquents making use of both casework and group work techniques, within the context of an entirely new type of boys' club, with the objective of discovering new ways of dealing with the early manifestations of delinquency.

Training for Clinical Psychology. Edited by MICHAEL H. P. FINN and FRED BROWN. (Pp. 186. \$4.00.) New York: International Universities Press. 1960.

This report of the proceedings of the Springfield-Mount Sinai Conferences on Intern Training in Clinical Psychology is specifically devoted to various aspects of psychological internship. Chapters deal with the selection of psychological interns, various aspects of training, the role of the University in relation to clinical psychology, conflict and identification in the training process, supervisory functions, and problems of communication in the training situation. Further chapters deal with research training, psychotherapy, and policies and standards.

Topical Problems of Psychotherapy. Edited by BERTHOLD STOKVIS. (Pp. 72. Sw. Fr. 11.70.) Basle/New York: S. Karger. 1960.

This publication contains papers in English, German and French. The contents include a consideration of the aim and problems of psychotherapy, its use with psychotic patients and in psychosomatic medicine. Included also are historical notes, fundamentals of group psychotherapy, psychotherapy and the picture of the human personality, and the results of psychotherapy.

The Priest and the Sick in Mind. By A. A. A. TERRUWE. (Pp. 123. 16s.) London: Burns Oates. 1959.

This work, written by a Catholic psychiatrist, attempts to give a guide to the various classes of neurosis and the characteristics of the different kinds of psychopath. The author has made certain modifications of Freudian analysis, and has made wide use of Thomistic categories.

The Central Nervous System and Behavior. Transactions of the Second Conference, 1959. Edited by MARY A. B. BRAZIER. (Pp. 358. \$4.75.) New York: Josiah Macy Jr. Foundation. 1959.

This report of one of the well-known Josiah Macy conferences includes a study of the limbic system with respect to basic life principles, the hippocampus and higher nervous activity, reversible decortication and behaviour, electroencephalographic studies in conditional reflex formation in man, and impressions of the colloquium on electroencephalography and higher nervous activity held in Moscow in 1958.

Treatise on Parapsychology. By RENÉ SUDRE. (Pp. 412. 35s.) London: George Allen and Unwin. 1960.

M. Sudre attempts to present a survey of all that has been accomplished from the beginnings of psychical research as a science to the present time. He reviews various phenomena, from water divining to hypnotism, and from telepathy to psychokinesis, placing them within the framework of a unified theory.

The Meaning of Death. Edited by HERMAN FEIFEL. (Pp. 351. 50s. 6d.) London: McGraw-Hill. 1959.

A number of papers on death have been culled from the literature and are presented together in this volume. Various sections deal with theoretical outlooks on death, developmental orientation toward death, the death concept in cultural and religious fields, and clinical and experimental studies. There is a substantial discussion of the papers by Gardner Murphy.

The Discovery of Reflexes. By E. G. T. LIDDELL. (Pp. 174. 30s.) London: Oxford University Press. 1960.

This is an historical account by Professor Liddell of the way in which the initial problems of reflexes were solved, and the progression within this field, with special reference to the pioneering work of Sherrington.

Mechanisms of Colour Discrimination. Edited by YVES GALIFRET. (Pp. 296. 63s.) London: Pergamon Press. 1960.

Leading zoologists, biochemists, neurophysiologists, psychophysicians and psychologists from twelve countries took part in the symposium reported in this book. Their object was to examine critically results obtained to date in the various special fields on the problems of chromatic discrimination in animals and man.

Social Science in Nursing. By FRANCES COOK MACGREGOR. (Pp. 354. \$5.00.) New York: Russell Sage Foundation. 1960.

This is the product of a three-year experimental project on the application of the Social Sciences to nursing. It interprets for the nursing student what the Social Sciences have to offer and shows how sociological concepts, methods and findings were developed and used to advantage in courses offered to students and faculty of the Cornell University—New York Hospital School of Nursing. Case histories are presented to illustrate situations that occur in illness, when medical personnel lack understanding of the social and cultural aspects of human behaviour. The study shows how nursing students can be helped to understand and accept patients whose customs, beliefs or behaviour are different from their own.

General Psychotherapy. By JOHN G. WATKINS. (Pp. 255. 74s.) Springfield: Charles Thomas; Oxford: Blackwell. 1960.

Dr Watkins organizes, in point form, a number of various systems, approaches, and techniques of psychotherapy. The book is intended as a guide to

the student of psychotherapy and to those who lecture in this subject. A large number of references are given.

An MMPI Codebook for Counselors. By L. E. DRAKE and E. R. OETTING. (Pp. 140. 30s.) Minnesota: University Press; London: Oxford University Press. 1960.

This manual is designed primarily as an aid to professional counsellors in the use of the Minnesota Multiphasic Personality Inventory.

Shapes of Sanity. By AINSLIE MEARES. (Pp. 468. £5. 8s.) Springfield: Charles Thomas; Oxford: Blackwell. 1960.

This is a study in the therapeutic use of modelling in the waking and hypnotic state. The technique is described as 'plastotherapy' and its role in diagnosis and treatment is discussed.

Hypnosis in Anaesthesiology. By MILTON J. MARMER. (Pp. 150. 54s.) Springfield: Charles Thomas; Oxford: Blackwell. 1959.

The author describes hypnotic techniques in detail, in a variety of operations, and gives frank and reasoned warnings on necessary precautions and possible pitfalls.

Constructive Work for Mental Health in Hong Kong. By K. E. PRIESTLEY. (Pp. 108. 7s. 6d.) Hong Kong: University Press; London: Oxford University Press. 1959.

Ten lectures by the Professor of Education at the University of Hong Kong.

The Student and Mental Health. Edited by DANIEL H. FUNKENSTEIN. (Pp. 495. £1. 15s.) Cambridge, U.S.A.: World Federation for Mental Health and the International Association of Universities. 1959.

This work presents an overall picture of the state of student health services in a great many countries. Abstracts of papers prepared for the conference are also included.

Drive Structure and Criminality. By HANS WALDER. (Pp. 174. 57s. 6d.) Springfield: Charles C. Thomas; Oxford: Blackwell. 1959.

An account is given in this work of the application of the Szondi test to criminals. This work is a translation from the German.

Molecules and Mental Health. Edited by FREDERIC A. GIBBS. (Pp. 189. 40s.) Philadelphia: Lippincott; London: Pitman Medical. 1959.

This book presents reports on and discussions of recent developments in the field of psychopharmacology.

Child Research in Psychopharmacology. Edited by SEYMOUR FISHER. (Pp. 216. 52s.) Springfield: Charles C. Thomas; Oxford: Blackwell. 1959.

The papers in this volume, a report of a symposium, are concerned with the philosophical, methodological and practical questions faced in organizing, carrying out, and evaluating studies of drug effects in children. An introductory chapter reviews psychopharmacological agents currently used, and a long reference list of drug studies in children is included.

Proceedings of the First International Congress of Neurological Sciences. Volume v. Edited by Dr LUDO VAN BOGAERT and Dr J. RADERMECKER. (Pp. 217. £3. 10s.) London: Pergamon Press. 1959.

Volume v reports the joint meetings and round table discussions of the specialists who attended the Congress. There is a full report of the conference 'Neurology at the Crossroads' as well as of the joint meetings on 'Extrapyrimal Psychology' and 'States of Consciousness in Neurology' (the latter under the chairmanship of Sir Geoffrey Jefferson).

Crime Documentaries—1. Guenther Podola. By RUPERT FURNEAUX. (Pp. 319. 18s. 6d.) London: Stevens and Sons Ltd. 1960.

An account of the Podola case, with appendices on policemen murdered in England and Wales since 1900, and the Scottish case of *Russell*.

A Functional Approach to Training in Clinical Psychology. By ABRAHAM LUCHINS. (Pp. 288. 60s.) Springfield: Charles C. Thomas; Oxford: Blackwell Scientific Publications. 1959.

A training programme for psychologists, organized around the study of a mental hospital, is described in this manual. An account is given of research projects that have as their scope the institutional analysis of a hospital and development of its therapeutic potentials, the hospital viewed as a therapeutic community. The roles that psychological trainees can play in the research projects are discussed in detail.

Yours by Choice. By JANE ROWE. (Pp. 148. 15s.) London: Mills and Boon. 1960.

A discussion of the problems involved in adopting a child. This is the first book on adoption to be published in England by a trained social worker.

Sigmund Freud's Mission. By ERICH FROMM. (Pp. 120. 12s. 6d.) London: Allen and Unwin. 1959.

This is a further analysis of Freud, in which Fromm presents his own point of view, emphasizing the fundamental discoveries of Freud, but attempting to show that Freud transformed Eros into sexuality and reason into rationalism.

The Pane of Glass. By JOHN BARTLOW MARTIN. (Pp. 397. 30s.) London: Gollancz. 1960.

This is an intensive study by a serious journalist of a typical state mental hospital in the United States.

Mental Health Problems of Automation. World Health Organization Technical Report Series No. 183. (Pp. 30. 1s. 9d.) Geneva: World Health Organization. 1959

The report of the W.H.O. Study Group presented here relates to the possible dangers of automation for the psychosocial foundations of human behaviour, and for the mental health of the individuals who are working in more or less automated factories or offices. Ways of preventing

these dangers are also discussed. The final section of this report deals with recommendations for research.

Africa—Social Change and Mental Health. (Pp. 40. 3s. 6d.) London: World Federation for Mental Health. 1959.

This pamphlet is an edited report of the discussion organized by the World Federation for Mental Health and attended by representatives of many different countries. It is the outcome of an increasing interest in Africa of the United Nations and its specialized agencies, and deals in particular with changes related to urbanization and industrialization, and the impact of Western ideas.

Truancy—or School Phobia? (Fifteenth Inter-Clinic Conference for Staffs of Child Guidance Clinics.) (Pp. 40. 3s. 6d.) London: National Association for Mental Health. 1959.

This is a report of a number of papers presented at an Inter-Clinic Conference for the Staffs of Child Guidance Clinics. It includes a useful bibliography of papers on school phobia and truancy.

Psychiatric Services and Architecture. By A. BAKER, R. L. DAVIES and P. SIVADON. (Pp. 59. 2s. 6d.) Geneva: World Health Organization. 1959.

This publication of the World Health Organization attempts an analysis of the planning and management of psychiatric hospitals, of the structure and function of other psychiatric services, psychiatric wards in general hospitals, rehabilitation facilities and other mental health services. It is the joint work of two psychiatrists and an architect who has specialized in hospital architecture, but it also takes into account the comments and suggestions of other architects and psychiatrists in various countries. The approach to the patient is

based on the desire to reintegrate him into society with all possible despatch, and to provide him with surroundings which will contribute to that end.

Baby Talk. By MORRIS VAL JONES. (Pp. 96. 36s.) Springfield: Charles C. Thomas; Oxford: Blackwell Scientific Publications Ltd. 1960.

This short work is concerned with infantile speech patterns and the author has attempted to assist parents to diagnose the speech problems of their children. He also gives some hints on therapy.

Handbook of Neurological Diagnostic Methods. Edited by FLETCHER MCDOWELL and HAROLD G. WOLFF. (Pp. 201. 36s.) London: Baillière, Tindall and Cox. 1960.

This book is the outgrowth of teaching experience and educational concepts developed in the Department of Medicine of the Cornell Medical College. The various sections deal not only with pure neurology techniques, but also take into account disorders involving personality and life adjustments. An account of the Cornell Medical Index, a self-administered health questionnaire, is also included.

A Pharmacologic Approach to the Study of the Mind. Edited by ROBERT M. FEATHERSTONE and ALEXANDER SIMON. (Pp. 399. 86s.) Springfield: Charles C. Thomas; Oxford: Blackwell. 1959.

This is a symposium including contributions from forty scientists in various fields. Its primary purpose is to assess the formulation of basic questions in the field now called 'psychopharmacology'. New data on the hallucinogenic compounds, tranquillizers and psychic energizers are contributed.

Psychotherapy 1961

By S. H. FOULKES*

I

Psychoanalysis has been the decisive influence in psychotherapy during the first half of this century. This is largely due to Freud's own contribution, to what he saw, and was not the result of his method. Freud could have made this contribution as a writer, thinker, poet or biologist.

What psychoanalysis means to us far exceeds its importance as a method of psychotherapy. It has transformed our picture of man and his motives, and influenced all spheres of thinking. One can only have a feeling of sympathy with those who try even now to keep away from the impact of this work or to deny it. By contrast, to others like myself, it has been a most significant experience in our lives. From the moment I first became acquainted with Freud's work in 1919 I knew that I wanted to devote my life to psychoanalysis, and I have never looked back. I wish therefore to make it clear that I am here concerned merely with psychoanalysis as a method of psychotherapy and as a theory of psychopathology. In this respect its greatest merits are the elucidation of unconscious processes, its concentration on the individual's problems in everyday life, his needs and anxieties, his happiness, hopes and despair, and the provision of a comprehensive theory based on biology.

In considering the second half of this century we are facing an altered situation. Twenty-one years have elapsed since Freud's death, and of his original collaborators only Jung, perhaps the greatest of them, is still with us. Freud's work must be taken as a whole, an historical fact, complete in so far as it cannot be developed further by anyone else. We are left with a method and a theory, and the question

is what we can do with them without Freud.

What is the situation today? The psychoanalytic school is a world-wide organization, but split into a great number of widely different groups, sometimes even within a single Psychoanalytic Society. Unfortunately the training analysis, the most significant experience of the future psychoanalyst, is dependent on the personalities of the analyst, the analysand and on their interaction.

Let us face the fact that psychoanalysis has not been able to produce a method which is sufficiently precise and well defined to serve as an instrument of investigation with reliable results if correctly applied. On the contrary, if we know the analyst and his convictions, we can predict fairly accurately beforehand what he will find. Anyone who makes new discoveries may perhaps do so with the help of this method, but on the basis of his own capacity to see things afresh.

Psychoanalysis as a psychotherapeutic method is of limited value, indicated and practicable only under selected conditions. Its contributions are part of psychotherapy as a whole, and of a scientific discipline of medical psychology, and have become absorbed into these.

In this paper I will emphasize the defensiveness of society against the therapeutic process and try to explain it, as I see it. In a preliminary way I should like to illustrate just how this tells on the level of everyday life.

While incubating this paper I happened to change my hairdresser. At the second or third visit, he found out, in spite of my reluctance to talk, that I was a psychiatrist, that I was at the Maudsley Hospital and in private practice. He told me that there were at least a dozen psychiatrists who had their hair cut at the same place, which happens not to be very far from

* Address from the Chair, Medical Section, British Psychological Society, 25 January 1961.

the Tavistock Clinic. He said they usually seemed 'far away', and often seemed to need treatment themselves. During this whole conversation my own replies were mostly confined to 'hmm' or 'Yes, yes' and similar noises. When he came up against my somewhat obstinate hair, he opined 'your hair needs hypnotizing, Sir!' This was considered a great joke all round. Each hairdresser and his respective client took up the thread: one heard laughter, funny remarks, and serious and mysterious sounding notions referring to hypnosis and psychiatry in general.

Next time, he returned to the subject, asking about several hospitals, all neurological in character, and the conversation turned to neurosurgery. He spoke with seriousness and respect of this discipline and its famous exponents. He then asked if I knew Dr X, to which I replied, 'Yes, he is very well known for hypnosis'. He said, 'That's right. There is a lot of difference of opinion about this. Another doctor I know says he doesn't think hypnosis is any good; it's all right for taking out a tooth, or for childbirth, but that's about all there is to it, and he doesn't recognize it as a treatment for these nervous troubles.' 'Hmmm', I said. 'We have a psychologist, you know, he doesn't believe in any of this—he says nothing at all is proved. He doesn't think there is anything in it at all. But then we have another psychologist—he doesn't believe in anything else. He says he can't recognize any treatment except the psychological one, and this usually takes something from two to four years; he doesn't think there is any other treatment for these conditions. Then we have a very distinguished physician who comes here and he says he doesn't think anything any good. He doesn't believe in psychiatry at all. He thinks that the practitioner should do it, the general practitioner could treat these conditions best. All these specialists, many of whom are not really qualified to treat these cases, did more harm than good.' I said: 'Yes, we ourselves think, too, that the general practitioner should treat these conditions, but then sometimes he cannot do so and he needs the help of a specialist

who is specially trained, as with anything else.' He understood this and continued to tell me that, on the other hand, he had recently read a book which stated that all medicine and all treatment should be based on psychology; indeed, that this was the treatment of the future.

II

Looking back now on more than 30 years of a life devoted to the study and treatment of the psychoneuroses, I may be permitted to ask the question: Why is our work so difficult? Why, in spite of the considerable knowledge and the profound insights we have gained during the last 50 years, are we still powerless to achieve more than comparatively minor changes and rearrangements in the inner dynamics and the mental economy of our patients? 'Whence does neurosis come—what is its ultimate, its own peculiar *raison d'être*?' asks Freud (1926), and continues: 'After tens of years of psychoanalytic labours, we are as much in the dark about this problem as we were at the start.' We have never overlooked the somatic basis of psychiatric conditions and the neuroses in particular. Freud spoke of neuroses as severe constitutional diseases. Yet, to say that the answer to our question is simply that we are up against the constitutional, that is unalterable, barrier, is not enough.

The further we penetrate in our analyses, the more we find that we are dealing with problems which involve everybody, and not with diseases which have descended upon our patients and of which we are to cure them.

The quotation from Freud occurs at the end of Part ix of *Inhibitions, Symptoms and Anxiety* (1926). Roughly 10 years after—only 2 years before his death—he presented us with another jewel, the produce of his solitary master mind. This article, 'Analysis, Terminable and Interminable' (1937), is Freud's last answer to our question.

We will for our purposes leave aside the important discussion of the problem of duration and completeness of psychoanalytical treatment, with which Freud's paper opens.

It ends on familiar ground, reaffirming the paramount importance of two themes: the wish for a penis in women and 'in men the struggle against their passive or feminine attitude towards other men'. For this latter, Adler's term 'masculine protest' is very apt, but in both sexes the central factor is a repudiation of femininity, which is conceived as castration. This seems to Freud a biological fact, not amenable to psychological influence, offering resistances to change which are unconquerable. Even if this resistance appears as a transference: 'The vital point is that it prevents any change from taking place—everything remains as it was.'

Limitations of psychoanalytic therapy are set in the first place by the strength of the instincts, which by definition cannot be changed, and must be controlled. The best we can do is to help the ego tame them. Our therapeutic efforts therefore turn to the ego. The ego, weakened by repression, repeats its defensive mechanisms during analysis. *The crucial point is that the ego treats recovery itself as a danger.* 'Nothing impresses us more strongly...than the feeling that there is a force at work which is defending itself by all possible means against recovery and is clinging tenaciously to illness and suffering.' The decisive variations in the ego are again seen as primary and congenital. Certain characteristics of the libido itself, such as 'adhesiveness', immobility or rigidity, may offer special resistance to change. Of great importance is the behaviour of the two primal instincts, their distribution, fusion and defusion.

The death instinct theory may not be tenable if applied to the isolated organism. If we look upon it as a quasi-poetical notion, applying to the living substance, 'life', as a whole it makes good sense. Personally I have become more and more convinced in the course of years of the truth and usefulness of the concept of a primary self-destructive force. Nothing is more certain than the ubiquity of destruction—a fact difficult to accept.

One of the greatest tasks still before us is to review all our knowledge of psychological

conflict from this new angle. Guilt and need for punishment are only localized, bound manifestations of this instinct.

These are limitations in the patient. What about the difficulties in the *analyst* himself? (These are of particular importance here in view of what I have to say later on.) The analyst as a psychotherapist should be mentally healthy, yet it cannot be disputed that he is frequently not as free from disturbance as he should ideally be. Every training analyst must be familiar with the intensity and subtlety with which his trainee repeats his own unresolved and reactivated conflicts with his own patients in turn, not only in projective reversal of his own warded off transference neurosis, but in genuine interaction with his patient's neurosis. This is one of the key positions for the understanding of the therapeutic process and its problems and limitations. These same observations can be made in the supervision of psychotherapists in training. The therapeutic situation in which these interactions can be best observed and corrected in my experience is in group analysis.

Provided this situation (in training) is competently handled, it is a unique occasion for working through the counter-transference problems of the future psychoanalyst. It should have the result, 'that the learner's own analysis will not cease to act upon him when that analysis ends, that the processes of ego-transformation will go on of their own accord and that he will bring his new insight to bear upon all his subsequent experience'.

I can well believe that this happy result is not too frequently achieved, but I doubt that, if it is not, further analysis, however often repeated, will bring it about. I suspect that the interminable analysands will produce more interminable analyses in turn.

The analyst, like his patient, may 'defend himself against recovery and cling tenaciously to illness and suffering'. Like his patient? Perhaps also through his patient! This disturbing thought occurred to me long ago: does the analyst defend himself by his very profession as a psychoanalyst, by analysing others?

I kept it carefully to myself until, in the course of a correspondence I had with Freud, about 5 years before the paper under discussion appeared, he himself touched on this point. He had encouraged me to study by what means analysts themselves resist the effects of analysis on their own person. I have indeed done so, but felt no wish to publish on this subject; perhaps as you listen to me tonight or read this paper, you will think that it is just as well. However, I communicated my suspicion to Freud as a tentative answer. He did not react to this at the time, but the whole question is taken up in the last part of chapter VII of his paper. The salient point is expressed in the following sentence: 'It looks as if a number of analysts learn to make use of defensive mechanisms which enable them to evade the conclusions and requirements of analysis themselves, probably by applying them to others. They themselves remain as they are and escape the critical and corrective influence of analysis.'

Today I see this whole problem as a special case of a general state of affairs, which can only be understood and remedied if we take the processes involved beyond the context of the individual in isolation.

The analyst, like any other human being, is dependent for his vital equilibrium on a dynamic system which comprises a number of persons in varying constellations. Unless he finds his basic satisfactions and balances with them, his unsaturated valences are bound to lead to a more realistic and serious interdependence with the patient, especially in view of the latter's enormous avidity for this. The analyst then deeply needs his patients, instead of offering the intense, but transient, sublimated relationship which the transference situation demands.

In this connexion it is striking to observe how dependent many analysts and psychotherapists seem to be on their patients and how little aware of this they often are. More recently some psychoanalysts, following the courageous example of Tower (1956), have drawn attention to observations on their own

persons and others, to the effect that the patient stimulates oedipal phantasies and reactions in the analyst. These observations are valuable and honest attempts to deal with this aspect of the countertransference problem. I am not sure whether Tower and others make this point, but it would appear to me that the oedipal, i.e. incestuous, nature of such reactions is provoked by the quasi-incestuous character of the psychoanalytic situation itself, with its particularly severe taboos. In the face of the patient's temptings under these circumstances, it is quite likely that any sexual appeal is liable to be linked in the unconscious mind of the analyst with unresolved oedipal or pre-oedipal strivings. Nevertheless, these analysts have often been extensively and successfully analysed. If their own analysis has not liberated them from these complexes, why has it not? Why should it do so, on being repeated?

On the whole then we find that psychoanalysis at the end of Freud's life has had to admit its very considerable limitations as a psychotherapy. Helene Deutsch (1959), reviewing some of her cases after 30 years, registers both disappointment and relief at Freud's paper and states: 'We do not eliminate the original source of neurosis; we only help to achieve better ability to change neurotic frustrations into valid compensations.'

Psychoanalysis thus remains what it has been from the beginning: the first scientific investigation into the nature and origin of neurotic symptoms or syndromes and, under favourable conditions, at the same time presents their cure. Psychoanalysis, it is clear, cannot finally solve the problem of neurosis. It must admit that this process is interminable.

III

At the end of Freud's life we find psychoanalysis confronted with very severe obstacles to further therapeutic progress. In fact, the limits of all psychotherapy seem to be in sight, in so far as they stem from constitutional or otherwise unalterable factors in human existence, which tell in patient and therapist alike.

Psychoanalysis is essentially a search for genetic origins. Its orientation is biological and it is part of the natural sciences. It must rest on the foundation of the physical organism. Inevitably therefore as it progresses in this direction, psychoanalysis must find quantitative factors, constitutionally given, at its frontiers. Freud had made this clear by stating that instinct has a dual aspect, a physical and a mental one. Its physical, material roots from which ultimately all energy is derived, are a matter for biology, and outside the domain of psychoanalysis. When he reached the frontier Freud found there was a gap on the other side—there was no biology waiting for him with which to link his new findings. However, there's the rub: what seemed a gap turned out to be a no-man's land of vast dimensions. It transpired that what was to become basic for psychoanalysis, e.g. the Oedipus and castration complexes, had their roots in this no-man's land. The need arose to resort to speculation. Freud built up on the most solid grounds he could find in the data of prehistoric developments and their interpretation, a line which was followed to a much greater extent by Jung. Others have tried to penetrate to ever-earlier developmental phases of the human individual—much earlier than Freud thought safe—in order to trace the evidence for these speculative assumptions. Inevitably the method employed in this search becomes more rather than less speculative and interpretative in character. Freud, in his theoretical system, has called this no-man's land the *id*, which is the mental reservoir of unconscious drive. This enabled psychoanalysis to keep up its 'Monroe Doctrine' and to continue its work for the time being unhampered with undue worry about developments in other fields. But this splendid isolation cannot go on forever! Meanwhile, other disciplines have not been standing still. Far from linking up smoothly with psychoanalytic theories, they proclaim them in part as untenable, in part as due for serious revision. Anthropological field research has thrown much new light on life in primitive communi-

ties, which invalidates the old theories; social psychologists tell us on good evidence that much that was called instinctive is, in fact, learned behaviour, and so forth. The emphasis shifts from the individual to the community or group. It is true that the family is a model of prime importance which recurs in all cultures, but the whole family constellation changes its character according to the culture (not the other way round). Modern zoology has arrived at the conclusion that cultural inheritance has superseded biological inheritance in its importance for the human species [Huxley]. Even Darwin's law of the survival of the fittest can be shown, experimentally, to operate in terms of the group rather than the individual. In the following I will show that the same development is taking place in psychotherapy. From the psychoanalytic side much valuable work is being done in the attempt to link psychoanalytic findings with these modern developments. Much of this is centred in the U.S.A. An example amongst many is Grinker's work in psychosomatics, and, in this country, the work of John Bowlby, who makes use of the fascinating findings in ethology. These workers feel that they must be open-minded about psychoanalytic theory, and be ready to modify or discard it wherever it is not the most useful to do justice to the facts. These attempts are in accordance with Freud's spirit, that is to say, with a scientific attitude, provided care is taken lest valuable insights, such as can perhaps only be gained on the grounds of psychoanalysis itself, are eliminated in the process.

Freud assumed without question that what psychoanalysis cannot do, no other method can do. Historically, he had every right to feel this way, in view of the overwhelming importance of his own contribution. Today it would seem to be necessary to make a distinction between the analytic and the psychotherapeutic function of the psychoanalyst, and not to identify the two.

This can best be demonstrated on the model of the transference situation. The psychoanalyst, as we know, submits the transference neurosis like anything else to the psycho-

analytic procedure. He wishes to destroy or dissolve it by reducing it to its original historic meaning in the infantile situation. He recognizes transference both as a positive communication concerning the infantile situation, and as a defence against such reductive genetic elucidation. This analytic process has a therapeutic effect which is optimal in the transference neuroses. Nevertheless, this therapeutic effect is a by-product only. Psychoanalysis gives priority to analysis; psychotherapy to the therapeutic processes and their study.

Psychotherapy can be radical and intensive when the therapeutic process, the therapeutic encounter, is put into the centre. There is evidence that therapeutic result is more dependent on personal qualifications on the part of both patient and therapist than is the latter's particular school. It would seem necessary therefore to concentrate on the experiences and processes that all can observe in their work with patients. We must express this experience in terms that can be shared by all, and formulate theories which lend themselves to scientific investigation.

Inside psychoanalysis therapeutic considerations have led to considerably more flexibility of method, according to the nature of the patient and his condition. This has been practised by many psychotherapists and some psychoanalysts for a long time, and is an example of what should be considered psychoanalytic psychotherapy. It is, of course, essential to give a clear theoretical account of such modifications in terms of the psychoanalytic situation and its parameters, rather than to make them intuitively and in a haphazard fashion. In my opinion all such variations should be defined in terms of the psychotherapeutic (T) situation, of which the psychoanalytic situation is one model.

While we are not concerned on this occasion with developments in psychotherapy on a broad front in any detail, it may at this point be recorded that much progress is being made in various fields.

Within the last ten years psychotherapists have become more alive to problems, have

become more daring, pioneering and experimental. Quite apart from action methods and a new appreciation of non-verbal communication, quite new (and very old) media of psychotherapy are being applied and studied—such as drama, dancing, music and many other methods of expression and communication; the growing influence of yoga and Zen Buddhism should be mentioned. Of the greatest social value would seem to be the new interest in studying and using the enormously powerful influences operating in communities, societies, teams and small groups, all of which can be used for therapeutic purposes on the basis of growing theoretical understanding on group analytic grounds.

These experiences seem at first sight far from the sphere of the individual psychotherapist, especially the psychoanalyst. Freud took a different attitude in *Civilization and its Discontents* (1930). He argues that one may be justified in considering whole epochs of civilization, perhaps whole humanity as neurotic (as Burrow had maintained), and continues: 'Following on the analytical dissection of such neuroses one might arrive at therapeutic propositions, which could claim a high practical interest' [my translation]. Later, Freud warns us to be careful not to transfer concepts, from the sphere in which they originated and developed, into another. This is very much my point of view, but it is difficult to prevent analysts and others to do just this: to transfer psychoanalytical concepts into the group situation. In the end, Freud states that, in spite of all these difficulties, one may expect that 'one day somebody will dare to undertake the pathology of cultural communities'. Well, we are in the middle of this process.

Personally, I find group psychotherapy particularly valuable, not only as a therapeutic method, but as a method of investigation into the therapeutic process and its impediments (1961).

Group-analysis is not so much concerned with the question of how people have become what they are than with the question: What changes them or prevents them from changing?

Why and how do they resist change, in spite of misery and suffering? By what means, with the help of what energies, do they do this? This, of course, is the salient question for all therapy and also all education. Strangely enough, the acknowledgement of the forces of self-destruction and their agencies helps us and makes us therapeutically far more powerful.

The main progressive trends in psychotherapy flow together in a recognizable direction.

It is characteristic of all modern developments to emphasize the experience which is made in the therapeutic situation itself. This is the essence of the 'here and now' of existential psychotherapy, which at long last hopes to come into its own. It would lead me too far here to go into the problems this raises, especially for the psychoanalyst. Quite briefly and inexact my view is: (1) that every good psychotherapist is or should be an existentialist in his actual contact with his patient; (2) that every existential analyst uses or should use the psychoanalytic method and procedure; (3) that psychoanalytic theory is biological in orientation, whereas existentialism is not. From this spring two dangers: (a) for the psychoanalyst: that it restricts him—perhaps inevitably—in his psychotherapeutic range; (b) for the existentialist: that he throws out the baby with the bath water.

The significance of the emotional experience in the treatment situation had not been overlooked by Freud and the early analysts. How could it be, as all therapy, all change, must of necessity be taking place in the present! Even at the cathartic stage it was clear that recollection alone is inefficient unless accompanied by emotional re-experience. Yet, characteristically, the essence of this was described in physiological terms of the isolated organism and called 'abreaction'. Equally characteristically, therapeutic effects based on unconscious emotional experiences, exchanges and discharges, however powerful, were not regarded as valid, unless they led eventually to conscious awareness and insight. 'Where id was, ego shall be' as Freud was able—much

later—to formulate. The concept of the transference neurosis and its analysis, so central for psychoanalytic therapy, is the very essence of the past coming into the 'here and now' of the treatment situation.

The work of Ferenczi and Rank, Karen Horney, Schultz Henke's Neoanalysis, Rado, the Washington School, Frieda Fromm-Reichmann, Erich Fromm, in spite of their differences, and notwithstanding the fact that some of them remained close to Freud's psychoanalysis, whereas others did not, have all in common this trend of putting the experience or re-experience in the therapeutic situation into the centre of their attention.

In recent times, Jules Masserman's work on dynamic psychiatry is perhaps the most comprehensive presentation of a psychopathology and psychotherapy on these, one might say, post-Freudian lines.

The tendency in all these neo- or post-Freudian developments is, however, to consider the present as more important than the past, in contrast to psychoanalysis.

In this country, Melanie Klein's work has helped to increase the range and depth of communication in the transference situation through its emphasis on object relations and unconscious phantasy. The basic model is that of transference and countertransference: two individual systems react upon each other each according to its own independent interpretation of the situation, based on the separate mental economy and psychodynamics of each.

Quite another aspect opens up when one takes this relationship as the basis for orientation and operation. Close and unprejudiced observation shows that this is not only possible but necessary. In the individual field, H. Stack Sullivan reoriented the whole of psychiatry in consequence of his interpersonal theory. The mutuality of this experience, the encounter between therapist and patient and the more active participation of the therapist are stressed.

My own work with groups has been guided by similar considerations. What is true for two persons is also true for three persons or any

number: as soon as they get into contact and communication they form a new unified field of interactional processes. The process of intercommunication, whether verbal or otherwise, and its theory, thus acquire a central position for all psychotherapy. Group psychotherapy thus becomes possible and even necessary.

Once formulated, these views can be relatively easily understood intellectually, but their real acceptance in the concrete situation is difficult, as they threaten firmly established positions. The change is one of attitude, and tells in the individual situation just as much as in the group situation.

To make my own view very clear at this point: for the full understanding of the individual's psychoneurosis, its history, the past remains of fundamental importance. Psychoanalysis is the method of choice for the exploration and reconstruction of this childhood neurosis. Psychoanalysis is a method of genetic research into biological origins. The transference neurosis should therefore be rightly considered as a repetition which is to be submitted to reductive analysis. By contrast, the relationship and interaction in the ongoing psychotherapeutic situation are of paramount importance for the therapeutic process and its study.

In addition: in so far as even in the original (childhood) situation, relationship and interaction may turn out to be of decisive importance, the past can come to life again under conditions which allow for change. Psychotherapy of a radical kind therefore becomes possible under many conditions which would not allow psychoanalytical genetic investigation.

IV

We have already mentioned that this emphasis on interpersonal transactional processes, on the group, is borne out by developments in biology itself. Instinct and ego in their constitutional aspects prove malleable to the influences which are transmitted from one generation to the other.

J. R. Carballo, of Madrid, in a recent article (1960) communicates pertinent observations and formulations from which the following are taken:

He speaks of the influence which is transmitted, impalpably and powerfully, from generation to generation. Even in the life of bacteria, so-called adaptive enzymes are transmitted from one generation to the next, without there being any question of heredity. Experiments by Liddell and Blauvelt concerning mammals, birds and reptiles, show that actions performed by the mother on the new-born are of decisive importance not only for the young animals' future social conduct but for the proper development of breathing, circulation, oxygenation of the blood, muscular strength and activity. 'The young animal that has missed those first acts of motherly care in their natural sequence will later on be a biologically deficient animal, a poor-looking thing, more susceptible to infections than others, and furthermore, unsocial and even neurotic... An untimely death is a frequent consequence, as in the children lacking affective protection whom Spitz studied.' It can be shown that even the 'constitution' of Yorkshire pigs, for example, is only to 60 % the outcome of Mendelian factors, and depends for the rest on the influence of man's psyche as expressed through the care, feeding and the first formative moulding. Living beings, most of all man, are born with incomplete adaptive structures. These are completed in a transactional reality, the nature of which is transmitted from generation to generation. What in psychoanalytical language is an object relation from the point of view of the child, is seen in ethology from the mother's standpoint as an imprint. Carballo sees in transference 'nothing but the reactivation of the primary object relation'. This is correct if we take the term transference in its broad meaning. Inside the psychoanalytic situation, the transference/counter-transference relationship represents this social interactional reality.

We see therefore that cultural factors enter even into the study of constitution itself, that

ego and super-ego are socially conditioned and quite certainly, that pathogenesis and cure depend essentially on the group. From all sides we are forced to the conclusion that the individual's emancipation from the group matrix is very incomplete. In our own field of psychotherapy and psychopathology this leads me to the conclusion that disturbances like psychoneuroses cannot be fully understood from the observation of the individual alone, but must be considered in the group context to which they belong.

The original neurotic manifestation in the childhood situation is but a symptom of a total constellation, a family neurosis so to speak. The acute neurotic breakdown in the adult is not merely a repetition in a transference setting, but a product of interactional processes in which a number of people are actively engaged. This insight—apart from its profound theoretical significance—is of very considerable practical importance for therapy.

I would like to mention a simple example of many years ago, the first, as far as I remember, in which I could make practical use of this view. My patient was one of a pair of twin brothers who, in addition, had married two sisters. They lived on a remote farm and it took him the best part of the day to come and see me. He was impotent. It is easy to imagine what complexity of interactions, identifications, etc., operated here. After two or three interviews it became clear to me that his sister-in-law, i.e. his wife's sister and his twin brother's wife, was a key figure, and I asked him to send her to see me. Fortunately she proved an intelligent and co-operative woman with good intuitive insight. When I saw my patient for the next and last time, his impotence had disappeared and he felt free from all disturbance. Five or six years later I by chance had occasion to hear that all had remained well ever since.

Over the years I have found that this multi-personal aspect is never absent, and that it is, in the great majority of cases, highly significant. Some examples have been indicated in a paper I read to this Section last year. May I also once

more remind you of Main's description of such a network in his Address from this chair 'The Ailment', read to this Society in 1957. The attempt to bring *this total network of neurotic interaction* into the open consciousness of all concerned, that is to say, in the same room and at the same time, often proves quite impossible in practice. More often than not it proves impossible even in thought and principle, because the complications arising can be foreseen to be overwhelming in their magnitude. Often, if not always, improvement in the patient provokes active, if largely unconscious, opposition on the part of others involved. I have given illustrations for this from ongoing psychotherapy, both in individual and group-situations. This opposition on the part of other members of the network tended to disrupt the treatment situation, and sometimes succeeded. In some examples it has been possible to demonstrate that this interference occurred with the precision of clockwork *at the very moment of a decisive change in the patient under treatment*.

Systematic investigations have been beyond my scope so far, but I have hopes to carry them out still. Others have been better placed in this respect, and their investigations confirm this experience. E. Lindemann at Harvard, for instance, showed that improvement in one patient led to the falling ill of other members of his family* (members of the interactional network in my terminology). The pathological process concentrates on another member or members of this network and becomes manifest in them.

This is one type of group psychotherapy which has as its object the natural, primary group—not necessarily identical with the family, but more nearly, if you like, the psychological family. It is not often practicable at present, though I believe that it will prove the key to further progress in the treatment and prophylaxis of disturbances in human interrelationships.

The other form of group psychotherapy

* Personal communication.

concerns groups of strangers in an analytic situation. This is, of course, immensely practicable, and its theoretical contribution may be even more important. I will not talk about this here. As in the usual psychotherapeutic, and particularly psychoanalytic situation, the individual is temporarily removed from his pathogenic network. This group-analytic group corresponds to a pure culture of these interactional processes in an innocuous setting, in a situation not predetermined by previous experiences, apart from those which each individual brings with him, and not determining future interpersonal relations. In this sense, perhaps, it is justified to call it an a-historic situation, which may lend itself to experimental investigation. Nowhere can these processes be so well studied, especially in their suprapersonal, transpersonal nature. It is not adequate to describe this as individuals who interact. It is, in my opinion, necessary to base one's practice and theory on the assumption of these processes interacting through the individuals who compose the psychical fabric of the group. One point of importance I would like to make: these processes are not the particular property of the group situation: they operate equally in life and in the individual psychotherapeutic situation. It is therefore not a matter of whether one practises what is technically called group psychotherapy or not. One is concerned with these forces just as well in the individual situation—though group observation is the optimal setting for their study.

If it is true that we are all involved in these problems and conflicts, it must also be true that we are dependent on others for our mental health. We must consider our own existence, the life we lead, in some respects as a device for keeping out of conflict at the expense of others.

The defensive aspect of the psychoanalyst's profession thus appears in yet another light. He really defends himself by analysing others, as I suspected so long ago. On the other hand, even the existentialist—this high priest of involvement—may use his patient to help him solve his own problems. There seems to be no

way out. The human observer is irreplaceable. The therapist is himself the instrument of observation and treatment, and psychotherapy depends on 'experience', understanding, communion, such as is only possible between two fully engaged persons. If we go to the other end of the scale we have the scientist who needs to be objective. He wishes to remain detached and in control of the situation. From the point of view of his personal motivation he tries to deny all involvement and tries to keep out altogether. If they are of the all-denying type and use this argument to question any value in our work, these scientists are not helpful to us; that is, to any Section such as ours. We must consistently show them their own involvement as expressed in their attitude.

With those scientists, however, who admit these problems into their orbit, we can co-operate and benefit from their criticisms. It must be admitted that many psychotherapists have no special knowledge of scientific method, have little information of developments outside their own field of interest and that their attitude may be equally irrational. What is needed is a truly scientific attitude which acknowledges our special difficulties and does not allow our vested interests as therapists to stand in the way of (objective) truth. This attitude is, however, as rare among psychotherapists as it is elsewhere.

Our task is to find ways and means for investigations which do justice to the complexities of our subject as well as live up to scientific criteria. In a recent article Riess (1960) gives a lucid account of these problems and interesting examples of such dynamic research. I would mention here also the type of research being carried out by Sandler and others at the Hampstead Child Therapy Centre as a good example, though it is more systematic than dynamic (Sandler, 1960).

Let us return to our cardinal question: 'Why is our work so difficult?' We have found that there is a basic defence against the resolution of the neurotic problem which emanates from the active and inevitable resistance of all

members of such a network towards change in any one of them.

This attitude is one which treats improvement or cure as a threat, and is well illustrated by the following examples taken from group-analytic experience.

(1) A foreign woman psychologist joined my group. She was happily married, had a child, and functioned well all round. She was not over-defensive and did her best to join in. Nevertheless, the group was very annoyed with her for having no problems and some members were driven to fury. When pressed, she said one day that she had always liked her parents, both her father and her mother. This was never forgotten and she was never forgiven. However, she continued to do well.

(2) A patient talked rather readily and much for a newcomer, and perhaps also in a slightly patronizing way. What he did say was good common sense, and psychologically appropriate; it was not 'analytic', but less defensive, if anything, than one could expect of someone who never had any psychotherapy. He said to the group, which contained a majority of expert and veteran analysts and that he had studied psychology for himself as a lay person, and that it had helped him a great deal. He gave a number of experiences which confirmed this. This made the group furious, and their anger was not mitigated when he asserted that he had plenty of problems, suffered from severe phobias, etc., and though one could help oneself to a certain degree, there were other aspects over which one needed help from other persons. At this point one of his neighbours pronounced that he would like to murder him. Another voiced her irritation and hatred in no uncertain terms. The group was only slightly appeased when I could reassure them that this man had, some years ago, had a very severe breakdown lasting over two years—the sort of breakdown which some of them spent half their lives avoiding.

There are other motives, of course. In both these examples there were, of course, other motives to be analysed, but what interests us here is the Gilbertian proposition that the qualification for membership in such a group seems to be that one is fundamentally disturbed, and that the idea of helping oneself, or getting well, is treated as the equivalent of high treason.

Fortunately the recognition of this multi-personal nature of the human problem at the same time brings with it new hope for its better solution. The general tendency towards the recognition of the social network has led to new methods of investigation and treatment, particularly group analysis in its various modifications, as well as to a different orientation within the treatment of the individual patients.

In theory, more stress is laid on the cultural and social roots of human behaviour. More recently this is also emerging in orthodox psychoanalytic theory, though perhaps it would not as yet be recognized in these terms.

It is not a question of a cultural versus a biological orientation, as these two aspects are intertwined and inseparable. As I have mentioned, modern biology itself moves in the direction of a better recognition of cultural or social inheritance.

All psychotherapy as a procedure, as a means to an end, is a concentrated revision in a specially designed situation. It may help decisively in terms of relative improvement within the context of the patient's life. Perhaps, in favourable cases, what occurs is a switch in the pathogenic network which leads to greater personal freedom of choice in the individual concerned.

We must get away from the categories of brief psychotherapy versus extensive or long psychotherapy, and replace them by radical in contrast to symptomatic psychotherapy. Weighing up all the factors on the basis of our growing discrimination, our aim is always the same: to achieve the optimal solution under existing conditions.

It may be helpful if I sum up some of the main themes in this paper:

(1) The work of Freud, and of psychoanalysis in the broad sense, has dominated the first half of this century. Its contributions will remain of paramount importance for all future progress. The second half of this century could develop a theory of psychopathology and psychotherapy based on a comprehensive view.

(2) The basic limitations of psychotherapy are seen by Freud as being due to biological factors, deemed to be unalterable. Modern research shows that much of what appeared to be biological inheritance is in fact cultural inheritance transmitted socially. In line with this, it perceives the community as a significant unit of observation.

(3) Within psychotherapy the same tendency is expressed by the emphasis on interactional processes, whether these are observed in two- or multi-personal situations.

(4) I have stressed the existence of a network of interaction, in which everybody tries to solve the conflicts common to all in interdependence with the others. The equilibrium of the individual, i.e. mental health, would therefore be dependent on his interaction with other members of the network. This leads to the method of analytical group observation and treatment in which the forces of the total network can be studied in their entirety—either in their natural setting or re-established in a transference situation.

(5) This method also has the particular merit that therapists of different backgrounds can look together afresh at events in a shared situation and thus find a common language for the processes which all recognize as operating, no matter to which school they may belong.

(6) In this view the neurotic would only be the weakest link in a chain, a scapegoat in a sense, and any change in him would have to contend with the automatic resistance of his network. In addition to the resistances to change which Freud so clearly perceived from the biological point of view, we have therefore to contend with this collective source of resistance. We are thus led to comprehend the defensive function of being a psychotherapist. We also understand the general and inevitable defence against our efforts.

Our work is indeed difficult, but it is intensely rewarding. All signposts—unless there is total destruction—point to such rapid development that, looking back from the year 2000, the first half of the twentieth century might well appear as remote as do the Middle Ages to us.

In this period of rapid and unprecedented change, the human individual will need the help of medical and remedial psychology more than anything else, if he is to survive and preserve his mental health. Medical psychology and psychotherapy will have to welcome and integrate all progress from wherever it may come. Fortunately there are signs that such progress is forthcoming and that integration has begun. If so, those who follow us will not fail.

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Disorders of attention and perception in early schizophrenia

BY ANDREW MCGHIE AND JAMES CHAPMAN*

Our main purpose here is to trace the development of a hypothesis relating to early schizophrenia and to outline a proposed method of investigation to test the validity of the theory advanced. In an earlier study of the chronic schizophrenic condition (Freeman, Cameron & McGhie, 1958), an attempt was made to outline a comprehensive theory which would account for the diverse pathological behaviour of chronic schizophrenic patients. Although this investigation was psychoanalytic in orientation, in its conceptual framework leaning heavily on Federn's (1953) theoretical model of the psychosis, the authors' observations led them to reject the proposal that schizophrenic symptoms are defensive activities purposefully related to unconscious conflicts over interpersonal difficulties. The basic pathological breakdown was observed to lie in an impairment of ego functions, particularly in the process of perception. It seemed to the authors that it would be more accurate to describe the process in reverse arguing that the breakdown in interpersonal difficulties was a reaction to the primary cognitive disturbance. A comparison of the chronic schizophrenic patient's behaviour with that of the young child (Freeman & McGhie, 1957) substantiated this view that the basic disturbance in schizophrenia was a cognitive one which caused the patient to operate at a perceptual level comparable to the primitive and unorganized processes characteristic of infancy and childhood.

Such observations are limited by the relative inability of the chronic patient to communicate directly and to describe his subjective experiences, in a comprehensive manner. Although it might be argued that the relative

inaccessibility of the chronic schizophrenic patient is an essential part of the disease process, it is very likely that it is also partially an artifact produced by prolonged hospitalization. In view of this, attention was turned to schizophrenic patients who could be observed at an early stage of their psychotic illness. One of the present authors (Chapman) examined a few of these early patients over a period of time in a psychotherapeutic setting and the clinical material which emerged in one of these cases was discussed in a later paper (Chapman, Freeman & McGhie, 1959). Such observations of a few early schizophrenic patients during psychotherapy endorsed the opinion that the fundamental disorder in schizophrenia was a cognitive one, most clearly evident in the fields of attention and perception, and that other aspects of the patient's symptomatology could be interpreted as his reactions to this basic disorder. It was also felt that a study of the early schizophrenic patient was much more rewarding in that the primary impairments were accessible to study, being unobscured by secondary reactions which occur in the later stages of the illness.

While the primary cognitive disturbance had earlier been described in terms of a breakdown of ego structure it seemed to the present authors that this theoretical framework was now too narrow, particularly in that it did not easily allow a theoretical *rapprochement* with work in other related fields. In continuing the clinical study on early schizophrenic patients the orientation was changed, not only to accentuate the patient's current mental activities, but also so that cognitive disturbances would constitute the main field of inquiry. A standard method of interviewing patients along these lines was drawn up and subsequently applied in a clinical study of early schizophrenic

* Dundee Royal Mental Hospital. Manuscript received 26 September 1960.

patients. The interview concentrated on recent changes in the patients' experiences and encouraged them to describe these changes in their own words. The clinical material was collected under categories which reflected the main areas of cognitive function. The most useful arrangement of categories was found to include the processes of attention, perception, motility and thinking. Attention was also paid to changes in affect which were observable. A total of twenty-six early schizophrenic patients, where the subsequent course of the illness confirmed the original diagnosis, were examined in this way and this report will deal mainly with the analysis of the clinical material so gathered, leading to a hypothesis regarding the nature of the primary disorder in schizophrenia.

The interviews were not carried out in a formal setting, the patient merely being encouraged to speak about his present difficulties and his speech recorded in the form of verbatim notes. In order to cover the full range of topics contained in the standard interview, it was necessary to see most of the patients concerned on several occasions, the total interviewing time for patients ranging thus from 2 to 12 hr.

CLINICAL MATERIAL

The interview material was analysed by breaking it up into a number of separate statements, each representing the patient's description of a symptomatic alteration in his experience. These separate statements were then arranged by the authors in categories which appeared to them to agree with the form and direction of the symptom being described. The small numbers in the group being studied obviously preclude any statistical analysis. As it is equally impossible to give a detailed description of each patient's account, the procedure here has been to give in each category a sample of the verbatim statements made by patients, which appear to the authors to have such a high incidence of frequency as to allow them to be considered as representative of the group as a whole. As will be apparent, the

assigning of many of these statements to different categories is to some extent arbitrary in that the patients' comments are at times equally relevant to two or more categories at the same time. This is of course not surprising, the categories representing divisions of the cognitive field which are in themselves artificial although useful for the purposes of analysis. Each statement reported here is prefaced by the patient's number in the group, this being done mainly to avoid the necessity of introducing each statement in turn.

(1) *Disturbances in the process of attention*

(Patient 11)—It's as if I am too wide awake—very, very alert. I can't relax at all. Everything seems to go through me. I just can't shut things out.

(Patient 5)—I listen to sounds all the time. I let all the sounds come in that are there. I should really get an earphone and a wireless and control these sounds coming in so that at least I know they are separate from me.

(Patient 13)—My concentration is very poor. I jump from one thing to another. If I am talking to someone they only need to cross their legs or scratch their heads and I am distracted and forget what I was saying. I think I could concentrate better with my eyes shut.

(Patient 14)—Things are coming in too fast. I lose my grip of it and get lost. I am attending to everything at once and as a result I do not really attend to anything.

(Patient 2)—I can't concentrate. It's diversion of attention that troubles me. I am picking up different conversations. It's like being a transmitter. The sounds are coming through to me but I feel my mind cannot cope with everything. It's difficult to concentrate on any one sound. It's like trying to do two or three different things at the one time.

(Patient 23)—Everything seems to grip my attention although I am not particularly interested in anything. I am speaking to you just now but I can hear noises going on next door and in the corridor. I find it difficult to shut these out and it makes it more difficult for me to concentrate on what I am saying to you. Often the silliest little things that are going on seem to interest me. That's not even true; they don't interest me but I find myself attending

to them and wasting a lot of time this way. I know that sounds like laziness but it's not really.

(Patient 7)—Everything that's going on seems to be picked up by me, almost as if I welcome these things to stop me attending fully to any one thing.

(Patient 6)—I am easily put off what I am doing or even what I am talking about. If something else is going on somewhere, even just a noise, it interrupts my thoughts and they get lost. If I am somewhere where there is a lot going on I am swinging from one thing to another instead of concentrating on one thing and getting it done.

(Patient 25)—I can't concentrate on television because I can't watch the screen and listen to what is being said at the same time. I can't seem to take in two things like this at the same time especially when one of them means watching and the other means listening. On the other hand I seem to be always taking in too much at the one time and then I can't handle it and can't make sense of it.

The implications of these comments will be considered in detail after we have examined the clinical material as a whole. One might, however, at this point note that the reports in this section appear to be related to a general factor of distractibility. These patients appear to have lost the ability and freedom to direct their attention *focally* as required in normal concentration. Their attention is instead directed *radially* in a manner which is determined, not by the individual's volition but by the diffuse pattern of stimuli existing in the total environmental situation. In effect, what seems to be happening is that the individual finds himself less free to direct his attention at will. Instead, his control of attention is now being increasingly determined for him by concrete changes in the environment. To this extent, the patient feels 'open', vulnerable and in danger of having his personal identity swamped by the incoming tide of impressions which he cannot control.

(2) Disturbances in the process of perception

(a) Changes in sensory quality

(Patient 2)—During the last while back I have noticed that noises all seem to be louder to me than they were before. It's as if someone had turned up the volume... I notice it most with background

noises—you know what I mean, noises that are always around but you don't notice them. Now they seem to be just as loud and sometimes louder than the main noises that are going on... It's a bit alarming at times because it makes it difficult to keep your mind on something when there's so much going on that you can't help listening to.

(Patient 17)—Colours seem to be brighter now, almost as if they are luminous. When I look around me it's like a luminous painting. I'm not sure if things are solid until I touch them.

(Patient 23)—Sometimes I feel alright then the next minute I feel that everything is coming towards me. I see things more than what they really are. Everything's brighter and louder and noisier.

(Patient 15)—I seem to be noticing colours more than before, although I am not artistically minded. The colours of things seem much more clearer and yet at the same time there is something missing. The things I look at seem to be flatter as if you were looking just at a surface. Maybe it's because I notice so much more about things and find myself looking at them for a longer time. Not only the colour of things fascinates me but all sorts of little things like markings in the surface, pick up my attention to.

(Patient 11)—I have noticed a lot recently that I seem to get a little mixed up about where sounds are coming from. Often I have to check up if someone speaks to me and several times I thought someone was shouting through the window when it was really the wireless at the front of the house.

(Patient 18)—I've had difficulty in tracing where sounds are coming from although I am not deaf. If the wireless is on, for example, I know the wireless is there but sometimes I feel that the sounds are coming from behind my back.

(Patient 10)—Have you ever had wax in your ears for a while and then had them syringed? That's what it's like now, as if I had been deaf before. Everything is much noisier and it excites me.

(b) Perception of speech

(Patient 5)—When people are talking I have to think what the words mean. You see, there is an interval instead of a spontaneous response. I have to think about it and it takes time. I have to pay all my attention to people when they are speaking or I get all mixed up and don't understand them.

(Patient 18)—If there are three or four people talking at one time I can't take it in. I would not be

able to hear what they were saying properly and I would get the one mixed up with the other. To me it's just like a babble—a noise that goes right through me.

(Patient 22)—When people are talking I just get scraps of it. If it is just one person who is speaking that's not so bad, but if others join in, then I can't pick it up at all. I just can't get into tune with that conversation. It makes me feel open—as if things are closing in on me and I have lost control.

(Patient 15)—It's the same with listening. You only hear snatches of conversation and you can't fit them together.

(Patient 9)—Sometimes when people speak to me my head is overloaded. It's too much to hold at once. It goes out as quick as it goes in. It makes you forget what you just heard because you can't get hearing it long enough. It's just words in the air unless you can figure it out from their faces.

(Patient 3)—When people are talking the words are going on and on and I don't understand them. It's extremely confusing—like going into a blank wall.

(Patient 12)—I'm slow in everything and everything is too quick. People speak to me but they go too quick for me to pick up. It's not that they talk too fast it's me that's slow.

(Patient 19)—I can concentrate quite well in what people are saying if they talk simply. It's when they go on into long sentences that I lose the meanings. It just becomes a lot of words that I would need to string together to make sense.

(Patient 6)—I'm a good listener but often I'm not really taking it in. I nod my head and smile but it's just a lot of jumbled up words to me.

(c) Perception and movement

(Patient 7)—I can't move if I am distracted by too much noise. I can't help stopping to listen. That's what happens when I am lying in bed. If there's too much noise going on I can't move.

(Patient 12)—I get stuck, almost as if I am paralysed at times. It may only last for a minute or two but it's a bit frightening. It seems to happen even when something unexpected takes place, especially if there's a lot of noise that comes on suddenly. Say I am walking across the floor and someone suddenly switches on the wireless, the music seems to stop me in my tracks and sometimes I freeze like that for a minute or two.

(Patient 22)—Sounds sometimes make me feel

dizzy. If I am looking at something and there's a sudden noise, perhaps an aeroplane passing or a bus, what I am looking at seems to swing or move in front of me although I know it's stationary. It makes me feel giddy but it does not last for long.

(Patient 3)—Everything is in bits. You put the picture up bit by bit into your head. It's like a photograph that's torn in bits and put together again. You have to absorb it again. If you move it's frightening. The picture you had in your head is still there but it's broken up. If I move there's a new picture that I have to put together again.

(Patient 5)—My responses are too slow. Things happen too quickly. There's too much to take in and I try to take in everything. Things happen but I don't respond. When something happens quickly or unexpectedly it stuns me like a shock. I just get stuck. I've got to be prepared and ready for such things. Nothing must come upon me too quickly.

(Patient 20)—When I have been rushing about I have to stop and be still for a minute. It's like watching a miniature railway. There is split second timing. One train misses the other by a split second. If I could walk slowly I would get on alright. My brain is going too quickly. If I move quickly I don't take things in. My brain is working alright but I am not responding to what is coming into it. My mind is always taking in little things at the side.

(Patient 14)—I don't like moving fast. I feel there would be a breakup if I went too quick. I can only stand that a short time and then I have to stop. If I carried on I wouldn't be aware of things as they really are. I would just be aware of the sound and the noise and the movements. Everything would be a jumbled mass. I have found that I can stop this happening by going completely still and motionless. When I do that, things are easier to take in.

(Patient 1)—When I move quickly it's a strain on me. Things go too quick for my mind. They get blurred and it's like being blind. It's as if you were seeing a picture one moment and another picture the next. I just stop and watch my feet. Everything is alright if I stop, but if I start moving again I lose control.

The first type of perceptual change reported by the patients appears as a heightening of sensory vividness which is experienced particularly in the auditory and visual fields. These subjective experiences might be interpreted as

a further extension of the loss in the selective function of attention as suggested in the previous section. In normal perception we are aware of only a small but significant sector of the total field of sensory stimulation. The reports here indicate that the patients find themselves attending, in an involuntary fashion, to features of their perceptual field which have hitherto occupied a background position. This widening of the range of conscious perception tends to disturb the constancy and stability of the perceptual matrix, thus causing a changing sense of subjective reality.

The second category of perceptual change is related to a disturbance in the perception of speech patterns. In normal communication incoming information is identified and fitted into context automatically, without the need of conscious intervention. Words are perceived, not as such, but as part of a total pattern of communication, following a specific theme which contains a positive sense of direction in its elaboration. This automatic ordering of the separate items of verbal communication into a meaningful sequence leaves the individual free to concentrate on the development of the theme rather than on its construction. From the reports given here it would seem that the patients are unable to appreciate the *content* of the communication because their conscious attention is taken up by the *form*. Their perceptual system is indeed overloaded and, unless enough time is allowed for both the form and content of the communication to be consciously assessed, effective registration does not take place. This dysfunction might be seen as related to the phenomenon of sensory vividness already discussed, in that both changes in experience result from the emergence into conscious awareness of perceptual features which have hitherto functioned autonomously.

In the third category of perceptual experience reported, the patients appear to be describing brief catatonic episodes which are causally related to changes in the auditory and visual fields. The production of a response in one sense modality by the stimulation of

another sense modality was noted earlier in a study of chronic schizophrenic patients (Freeman & McGhie, 1957) and was also reported in a detailed study of a young patient (Chapman *et al.* 1959). This type of perceptual fusion, similar to synaesthesia, is the basis of Werner & Wapners's concept of 'functional equivalence', which they found to be present in the behaviour of young children. In their experiments it was found that both auditory and tactile stimulation led to an identical perceptual change in the visual field. The descriptions given by the patients also correspond with Piaget's (1951) studies of early perceptual development in childhood when the slightest alteration in the perceptual field results in the whole structure of that field being altered. In this primitive and undifferentiated state motility and perception are intimately linked, motility being dependent upon stability of the perceptual field. The same process would seem to lie behind the difficulties of these early schizophrenic patients who declare 'Everything is all right if I stop, but if I start moving again I lose control'. The early schizophrenic patient thus demonstrates in his reactions a pronounced degree of diffuseness between normally discrete sensory channels and a lack of stability in perception. Once again we see the young schizophrenic patient finding himself faced with a new unstable and fluctuating relationship with his environment in which he no longer exerts the initiative.

(3) *Changes in motility and bodily awareness*

(Patient 18)—I am not sure of my own movements any more. It's very hard to describe this but at times I am not sure about even simple actions like sitting down. It's not so much thinking out what to do, it's the doing of it that sticks me... I found recently that I was thinking of myself doing things before I would do them. If I am going to sit down, for example, I have got to think of myself and almost see myself sitting down before I do it. It's the same with other things like washing, eating and even dressing—things that I have done at one time without even bothering or thinking about at all... All this makes me move much slower now.

I take more time to do things because I am always conscious of what I am doing. If I could just stop noticing what I am doing, I would get things done a lot faster.

(Patient 11)—You see I've got to think ahead before rushing into something. If I went straight ahead I might fall down or something. I've got to see that the path is clear.

(Patient 12)—If you move fast without thinking, co-ordination becomes difficult and everything becomes mechanical. I prefer to think out movements first before I do anything, then I get up slowly and do it.

(Patient 23)—People just do things but I have to watch first to see how you do things. I have to think out most things first and know how to do them before I do them. When I am racing and am ready to get off the mark I have to think of putting my hands down in front of me and how to lift my legs before I can start.

(Patient 19)—I have got to see ahead. I keep to a pattern. If you rush you might do things wrong. If people rush at things their minds are probably away somewhere else anyway, but I know what's happening all the time.

(Patient 7)—Anticipation is one of my worst habits. I have to think of what I am going to do all the time and that takes up a lot of energy and when I am doing something I am aware of my every movement.

(Patient 14)—If I am doing something then I start thinking of what I am doing, that locks me up in a sense. For example, if I drop something and stop to pick it up, if I start to think of myself in that position and what I am doing, that locks me up in that position. If you keep thinking of where your body is it gets locked up.

(Patient 3)—I have to do everything step by step, nothing is automatic now. Everything has to be considered.

(Patient 17)—People go about completely unthinking. They do things automatically. A man can walk down the street and not bother. If he stops to think about it he might look at his legs and just wonder where he is going to get the energy to move his legs. His legs will start to wobble. How does he know that his legs are going to move when he wants them to.

One of the most important features of normal motility is our ability to initiate and carry out sequences of motor response without

conscious deliberation. Through repetition we gradually build up a store of activities, simple and complex, which require only an awareness of an end goal to reproduce the activity in a spontaneous and skilled manner. Without this automatic regulative function normal behaviour would be hopelessly complex, requiring conscious co-ordination of every simple sequence of movement. The descriptions of these patients indicate a loss of this spontaneity caused by a heightened awareness of the bodily sensations and volitional impulses normally lying outside of conscious experience. Each action now has to be planned and executed step by step with a great deal of conscious deliberation. The patient finds himself becoming increasingly 'self-conscious' in an entirely literal sense.

(4) *Changes in the process of thinking*

(Patient 9)—My thoughts get all jumbled up. I start thinking or talking about something but I never get there. Instead I wander off in the wrong direction and get caught up with all sorts of different things that may be connected with the things I want to say but in a way I can't explain. People listening to me get more lost than I do.

(Patient 20)—My trouble is that I've got too many thoughts. You might think about something, let's say that ashtray and just think, oh! yes, that's for putting my cigarette in, but I would think of it and then I would think of a dozen different things connected with it at the same time.

(Patient 21)—My mind's away. I have lost control. There are too many things coming into my head at once and I can't sort them out.

(Patient 6)—My mind is going too quick for me. It is all bamboozled. All the things are going too quick for me. Everything's too fast and too big for me.

(Patient 15)—It's not that I can't concentrate right, it's just that I can't concentrate on the major issues. I get fogged up with all the different bits and lose the important things in the picture. I find myself paying attention to all sorts of tiny things instead of getting on with the things I should be doing. I have to concentrate on simple things like walking, peddling my bike and even talking.

(Patient 22)—I let my mind wander for a minute but sometimes for half an hour. I just go into

myself. I just stop moving. I may be looking at something in a window for example, and then I find myself thinking deeper and getting caught up in it. My mind can't move past it. When I come to, I find I have been just thinking about the one thing for a long time and I panic, and then I start to worry if people have seen me.

(*Patient 4*)—I may be thinking quite clearly and telling someone something and suddenly I get stuck. You have seen me do this and you may think I am just lost for words or that I have gone into a trance, but that is not what happens. What happens is that I suddenly stick on a word or an idea in my head and I just can't move past it. It seems to fill my mind and there's no room for anything else. This might go on for a while and suddenly it's over. Afterwards I get a feeling that I have been thinking very deeply about whatever it was but often I can't remember what it was that has filled my mind so completely.

(*Patient 13*)—If I am reading I may suddenly get bogged down at a word. It may be any word, even a simple word that I know well. When this happens I can't get past it. It's as if I am being hypnotized by it. It's as if I am seeing the word for the first time and in a different way from anyone else. It's not so much that I absorb it, it's more like it absorbing me.

(*Patient 18*)—I just can't concentrate on anything. There's too much going on in my head and I can't sort it out. My thoughts wander round in circles without getting anywhere. I try to read even a paragraph in a book but it takes me ages because each bit I read starts me thinking in ten different directions at once.

(*Patient 2*)—When I am trying to think of something I am like a railway engine running along a line where someone keeps changing the points.

(*Patient 4*)—It's either one extreme or the other with me. Sometimes I can't concentrate because my brain is going too fast and at other times it is either going too slow or has stopped altogether. I don't mean that my mind becomes a blank, it just gets stuck in a rut when I am thinking over and over again about one thing. It's just as if there was a crack in the record.

Normal thinking involves the purposeful manipulation of the internal images and ideas which form our stock of previously acquired information. In bringing our thoughts to bear on a specific problem we abstract from the total

field of information that which is relevant to the task in hand. Thinking, or more accurately, reasoning, is thus a highly selective process in which inhibition is intimately linked with the degree of abstractness of the thought product. Indeed, the concept of control, direction and inhibition is central to the process of logical reasoning. In conditions of relaxed control, such as in the hypnagogic state and in sleep, our thinking loses this sense of direction and is no longer orientated towards reality. Logical sequences of ideas are replaced by merely associative sequences and the thought level passes from the abstract to the concrete. It is this very lack of control, direction and inhibition which characterizes the disturbances of thinking reported by our patients. As one of the patients put it during interview—'I wish I could think without interruption—not from others but from inside myself.'

(5) *Changes in the affective process*

(*Patient 2*)—You have no idea what it's like doctor. You would have to experience it yourself. When you feel yourself going into a sort of coma you get really scared. It's like waiting on a landing craft going into D. Day. You tremble and panic. It's like no other fear on earth.

(*Patient 7*)—When I am walking along the street it comes on me. I start to think deeply and I start to go into a sort of trance. I think so deep that I almost get out of this world. Then you get frightened that you are going to get into a jam and lose yourself. That's when I get worried and excited.

(*Patient 21*)—Things just happen to me now and I have no control over them. I don't seem to have the same say in things any more. At times I can't even control what I want to think about. I am starting to feel pretty numb about everything because I am becoming an object and objects don't have feelings.

(*Patient 19*)—Half the time I am talking about one thing and thinking about half a dozen other things at the same time. It must look queer to people when I laugh about something that has got nothing to do with what I am talking about, but they don't know what's going on inside and how much of it is running round in my head. You see I might be talking about something quite serious

to you and other things come into my head at the same time that are funny and this makes me laugh. If I could only concentrate on the one thing at the one time I wouldn't look half so silly.

(Patient 14)—It's just that I seem to be changing and I can't do anything about it. I feel I am losing myself more each day. That's bad enough but it's the vagueness of the whole thing that really troubles me. If the things that were happening were clearer so you could put them into words and tell somebody what it's like without sounding quite daft it wouldn't be so bad.

The comments made by the patients suggest that the affective changes reported are causally related to the cognitive changes which we have already described. These patients (e.g. patients 2 and 7) first react with perplexity, anxiety and panic to the pathological changes in their experience into which, at this stage of their illness, they have a fair degree of insight. Later, as they find themselves gradually losing control over cognitive and volitional activities the mental and bodily ego is experienced as increasingly alien (patients 21, 19 and 14). Losing their subjectivity they are becoming objects and, as one patient said, 'objects don't have feelings'. The main point we would wish to make here however is that when these affective changes are reported they would appear to be secondary and to follow as reactions to the patient's awareness of the primary cognitive changes which have already taken place.

DISCUSSION

Studies of early ego development, particularly those by genetic psychologists such as Piaget and Werner, indicate that the first stages of infancy are characterized by an undifferentiated protoplasmic consciousness in which there is no differentiation between the self and the outside world; no self awareness; no consciousness of external objects. This stage of adualism, which approximates to the Freudian concept of an undifferentiated ego-id, is gradually superseded by the individuation of the developing ego. In these early stages of infancy it would appear that the infant pas-

sively assimilates or incorporates mental experiences in an indiscriminated fashion whether these experiences originate externally from the environment or internally within the infant's own body. The process of perception at this time is primitive, global and undifferentiated, the infant having virtually no control over the mass of incoming sensory stimuli reaching his primitive nervous system. In its subsequent development the ego must gain increasing degree of mastery over its environment by controlling and organizing the incoming flow of sensory stimuli. For this to take place we must postulate an internal mechanism which allows the organism to select from this diffuse sensory input the information necessary to allow it to function efficiently. To a large extent adjustment to the environment, and the development of a differentiated ego, develops by a process of selection and inhibition of incoming sensory stimuli, so that only part of the whole sensory background is effectively registered in consciousness.

It is perhaps as well if we pause at this point to define in more detail our use of the word 'consciousness'. In examining the variety of meanings given to the term in the Symposium *Brain Mechanisms and Consciousness* (1954), Brain (1958) finds that the term may be used to mean at least six different things. Among the definitions of consciousness given in the Symposium to which Brain referred we might select the following statement by Jung (1954) as being nearest to our own interpretation: 'Consciousness is considered as a selective and restraining function for limiting actual psychic experience amongst the many potentially psychic phenomena which remain unconscious. Attention is a co-ordinating aid for conscious perception and may be compared to a spotlight which illuminates details in the dark unconscious field of the internal and external world....Attention assists consciousness by selecting inner experience and outer perceptions from the sense organs, so illuminating a section of the internal and external world.' By the process of attention we thus break down

and effectively categorise both the information reaching us from the environment, and that which is internally available in the form of stored past experience. It would seem that in the earlier stages of development, consciousness consists merely of a passive assimilation of sensations, and that perception is then dependent upon each change in the sensory input. We have already referred to this primitive mode of perception, where any change in the perceptual field causes the whole structure of that field to be altered. Gradually, however, the organism becomes more active and able to integrate the incoming data from the sense organs with previous experience. Perception is thus finally stabilized by our capacity to modify the incoming pattern of stimulation to provide a degree of perceptual constancy. By such processes we reduce, organize and interpret the otherwise chaotic flow of information reaching consciousness to a limited number of differentiated, stable and meaningful percepts from which our reality is constructed.

During subsequent development another important process of selection develops which allows us to master our environment in an economic manner. Activities which are repeated over a period of time tend to become automatic and function spontaneously with the minimal utilization of voluntary attention.

This removal of certain ego functions from conscious attention corresponds of course to the Freudian concept of preconscious function. Kubie (1954) describes this process in the following way:

Preconscious processes drop out of the central focus of consciousness through repetition. Thus all simple activities of life such as breathing, sucking, excreting, moving, crying, are originally random and often explosive acts. Early in life their purposeful execution is learned through repetition, by which they become economically organized into synergistic, goal-directed patterns. As any such act is fully learned, it can be initiated simply by a contemplation of its goal; and as this happens we gradually become unaware of the intermediate steps which make up the act. This great economy is achieved in the process of learning by repetition. It is in this way that we become able to walk

without pondering each step, to talk without working out the movements by which we enunciate each word. . . . The importance of this preconscious system of conscious function cannot be overestimated. . . . It is inconceivable that we could have any scientific, artistic, literary, mathematical, or indeed any creative functions without the capacity for enormous economies which pre-conscious processes possess.

In his analysis of skilled performance Welford (1958) makes the interesting suggestion that 'the decision mechanism' of conscious attention is concerned with 'the resolution of uncertainty'. He describes this process as follows: 'More generally the view seems to be tenable that what we recognize as consciousness in the full sense—as opposed to merely not being asleep—arises essentially when some uncertainty requires to be resolved and that the apparent loss of conscious control in highly practised skills is a result of the virtual elimination of uncertainty in performance. . . . On this view, when a performance is so thoroughly learned that it becomes "automatic", it can be carried on while leaving the decision mechanism virtually free.' Thus, by repetition and the resolution of uncertainty, conscious attention becomes less bound to concrete stimulation and freer to participate in higher mental processes where uncertainty plays a dominant role.

Although it seems unlikely that we can ever define consciousness in purely physiological terms, work in recent years has certainly provided us with evidence for some neurological correlates of conscious mental activity. The role of the brain stem reticular system now appears to be central to the development of conscious functions and it now seems likely that this system makes possible the selective monitoring of incoming information upon which adequate ego functioning is dependent. Brain (1958) concludes his survey of the reticular system's relationship with the process of attention by declaring '...it looks rather as though its (the reticular system) function were to prepare not only the cortex but the other sensory pathways also to respond to a sensory

impulse when it has arrived. As we have seen, such responses are at least twofold, namely the reduction of other sensory "information" which might compete for attention, and the integration of the sensory "information" being attended to with the continuously changing background of somatic and environmental sensory data.' Penfield (1954) in his concept of the centrencephalic system reaches the following somewhat similar conclusion, '...the hypothesis is suggested that sensory information is integrated within the centrencephalic system. A selected portion of this information is then somehow projected upwards to the temporal cortex by the portion of the system which is in functional connexion with the temporal cortex of both sides. As it is thus projected, a comparison is made with past similar experiences, thanks to records of the past that are held there, and judgement with regard to familiarity and significance is made.' Here, it would seem, is the 'spotlight' of attention which allows us to deal with our environment in an economic and effective manner.

Now let us suppose that there is a breakdown in this selective-inhibitory function of attention. Consciousness would be flooded with an undifferentiated mass of incoming sensory data, transmitted from the environment via the sense organs. To this involuntary tide of impressions there would be added the diverse internal images, and their associations, which would no longer be co-ordinated with incoming information. Perception would revert to the passive and involuntary assimilative process of early childhood and, if the incoming flood were to carry on unchecked, it would gradually sweep away the stable constructs of a former reality. Let us now summarize the findings of the present clinical study with this picture in mind.

The schizophrenic patients in the present study describe, at times vividly, the primitive, global and undifferentiated nature of their perceptions. Recently a number of investigations have been reported dealing with disturbances of perception in mental illness and there is now sufficient experimental evidence

to support the assertion that perceptual constancy and selectivity is disturbed particularly in the case of schizophrenia. Wechowicz (1957) and Wechowicz, Somner & Hall (1958) have reported a disturbance in both distance and size constancy in chronic schizophrenic patients. Commenting on their findings they declared that 'Schizophrenic patients live in a visual world which is lacking in depth (three dimensionality) and the perception of these patients is more literal and less related to the third dimension than the perception of normals.' Our patients' comments indicate the same concrete response to the environment and a disturbed perceptual constancy. Their descriptions also imply some degree of perceptual fusion of normally discrete sensory channels, further evidence of a primitivization of the whole perceptual process.

The loss of spontaneity in behaviour which they describe would seem to be a natural consequence of their conscious attention being invaded by the volitional impulses and stimuli from the effectors which normally function autonomously outside of the range of awareness. The patient now has consciously to initiate and control his bodily movements, every one of which involves a decision. Activities which were before self-regulative are now experienced as uncertain and requiring deliberate co-ordination. It is small wonder that the patient speaks of a split between his mind and body, and feels that he is in danger of losing control over his own actions.

The patient finds difficulty in ordering, not only his movements, but also his thoughts. Like his movements the patient's thoughts are non-volitional, unco-ordinated, and subject to sudden stops. The disturbance of thinking again reflects the fundamental loss of the normal mechanism of selective-inhibitory control of attention. This conclusion is in accordance with the many studies already made of schizophrenic thought disorders which invariably reach one conclusion in common. Schilder (1951) speaks of the schizophrenic patient being '...unable to pursue the determinative idea'. Cameron (1944) refers to over-

inclusion 'as a central factor in schizophrenic thought disorder', while Arieti (1955) speaks of '...a lack of inhibition of peripheral ideas necessary for effective abstraction'. McKellar (1957) explains the loss of abstract thinking in schizophrenia as being due to 'the inability to inhibit associated but irrelevant ideas'. In a report of a recent investigation carried out at the Maudsley Hospital the main conclusion was as follows: 'Over-inclusive thinking is due to a defect in some central filter which is responsible for screening out stimuli, both internal and external, which are irrelevant to the task in hand... This filter presumably operates by inhibiting those stimuli by some process similar to that described by Pavlov... It is conceivable that schizophrenics are abnormal in that they do not readily develop any kind of cortical inhibition' (Payne, Mattussek & George, 1959). In a recent paper (Weckowicz & Blewett, 1959) the relationship between one aspect of perceptual disorder, size constancy and the disturbance of abstract thinking in chronic schizophrenics has been examined and the findings here tend to confirm a correlation between perceptual constancy and abstract thinking. These authors conclude that the abnormalities of thinking and perception in schizophrenic patients are secondary and causally related to a basic inability to attend selectively to the incoming sensory input from the environment. The clinical findings in the present study would appear to point in the same direction, suggesting that the disturbances of perception and thinking in early schizophrenics are secondary to the primary disturbances in the control of the direction of attention.

We have already considered the affective changes which take place, and argued that these are secondary and consequent upon the basic cognitive disturbance. It would seem to us in fact that all other apparently irrational features of schizophrenic behaviour also represent attempts made by the patient to cope with, and rationalize, his changing experience. Many of the apparently bizarre and meaningless activities of schizophrenic patients become

more rational if we consider their function in aiding the patient to find a new level of adaptation. This goes beyond the scope of the present discussion, but we might cite the example of several patients whose habit of stuffing their ears with cotton wool and closing their eyes becomes more intelligible once the defensive function of their actions were understood. One might also note in passing that, if our view of schizophrenic experience is correct, then the paranoid patient's description of a hostile environment which seeks to control him is perhaps a valid reflexion of his view of reality.

From the point of view of etiology, it would seem that, if schizophrenia is a disease which has its basic effect in a disruption of the control of attention, then the reticular system may be the main pathological site.

Symonds (1954), in his discussion of the reticular system, makes the following comments which appear to us to be highly relevant to the present subject:

There is much evidence suggesting the existence of tonic activity from the cortex, and probably from the brain stem and cerebellum, having an inhibitory effect on synapses of the afferent pathways... Further studies on the unanaesthetized cat by means of implanting electrodes suggests that inhibition of afferent inflow may be selective and its direction governed by attention so that, for example, impulses set up in the visual pathways by photic stimulation are depressed when the animal is at the same time exposed to auditory or olfactory stimulus... If it is accepted that the afferent flow to the cortex is thus subject to voluntary control, what might happen if this control were withdrawn?

Although Symonds was not considering mental illness in his discussion, the answer to his last question concerning a breakdown in the reticular system, resulting in the cortex being bombarded with irrelevant information, might be schizophrenia. It may be pertinent that the tranquilizing drugs which are most effective in schizophrenia are thought to operate by exercising an inhibitory effect upon subcortical areas including that covered by the reticular system.

A PROPOSED STUDY OF EARLY SCHIZOPHRENIA

A clinical study of the phenomena reported by early schizophrenics has led us to a hypothesis which might be stated as follows: The earliest reported symptoms of a schizophrenic illness indicate that a primary disorder is that of a decrease in the selective and inhibitory functions of attention. The disturbance in this process leads to a number of other pathological changes which include:

(1) A primitivization of the perceptual process resulting in a gradual tendency for perception to become global, undifferentiated and lacking in spatio-temporal constancy.

(2) A progressive diffuseness in the operation of hitherto discrete sensory channels, which may be likened to the phenomenon of synesthesia.

(3) Disturbances in the control and direction of motility or willed action which appears as a heightened awareness of bodily functions and volitional impulses which are normally outside of the range of conscious awareness.

(4) A decrease in concentration and progressive thought disorder related to the basic inability to abstract from the incoming flow of information and its internal association that which is pertinent to a logical sequence of thinking.

The most obvious way of testing the validity of this hypothesis would take the form of a further more intensive examination of a group of established schizophrenic patients. There are, however, two main disadvantages to this approach. The initial selection of the subjects is dependent upon the classical diagnosis of schizophrenia which is subject to observer variation. In order to overcome diagnostic difficulties it is thus necessary to confine one's investigation to schizophrenic patients whose symptoms are of long duration, where the course of the disease has placed the diagnosis beyond doubt. This restriction of examination to chronic schizophrenic patients raises the second difficulty, in that evidence of the primary disorder in such patients is apt to be

obscured by the secondary reactions and the general deterioration which is consequent upon the chronic state. The methodology of investigation is further limited by the relative inaccessibility of many chronic patients and their inability to act as reliable subjects in experimental procedures. In view of these difficulties it is intended to confine the proposed investigation to patients who are as yet in the early stages of their illness. It is hoped to circumvent some of the uncertainties of early diagnosis by widening the investigation to include all patients presented for their first psychiatric consultation within a stated age range (17-25 years) *regardless* of the psychiatric diagnosis made on referral. Each patient will be observed over a period by means of a standardized interview technique and by a series of experimental methods designed to assess the hypothetical phenomena already outlined. According to the findings provided by these two independent sets of data it should be possible to isolate those patients whose responses show a pattern in accordance with our hypothesis. The remaining patients will of course then automatically function as controls. The patients will be subsequently followed up, their psychiatric progress assessed at a later date and subsequently compared with the clinical and experimental findings.

These experimental techniques have been designed to examine objectively each of the areas of cognitive change reported by the patients in the present clinical study. By these methods it is hoped to obtain indices representing pathological changes in such functions as that of selective attention, perceptual stability and sequential thinking. Particular attention will be paid to the influence of stimulation in one sensory channel on the output of alternative channels, in an attempt to isolate the phenomenon of perceptual 'fusion' which is so characteristic of the reports of schizophrenic patients. Some indication of disorder in the field of motility will be obtained by selected tests of the effect produced by visual and auditory stimulation on motor performance.

This clinical-experimental approach provides a means of testing the hypothesis that certain schizophrenic symptoms are a result of a disturbance in the selective-inhibitory mechanism of attention. The findings of the investigation may also add to our competence in making an early differential diagnosis of schizophrenia. One of the current beliefs in some quarters of psychiatry is that clinical psychiatry need no longer be concerned with the field of psychotic illness which is proving to be a biochemical problem, the solution to which will some day be provided by the biochemists. While one does not doubt that ultimately the contributions of biochemistry and neurophysiology will play a decisive role in delineating the etiological factors behind the schizophrenic disturbance, there seems little doubt that clinical psychiatry must still be an active participant. Indeed, one might argue that there is little chance of the organic components of the illness being identified until psychiatry can provide a more exacting classification of schizophrenic disorders. To do this we must seek to define and measure schizophrenic states in a more specific and detailed way, keeping in mind the possible organic implications of our clinical findings. If psychiatry can perform this task efficiently it might then be possible to approach the biochemist and neurophysiologist with a set of clearly defined questions to which there would be some possibility of an answer. Schizophrenia, which has so long eluded our full understanding, is much too complex a problem ever to be solved by an approach limited to one method of inquiry. It requires an approach, which in terminology, methodology and theoretical construction, is flexible enough to embrace the whole field of psychiatric

research. In the development of our own thinking on this subject we have found it necessary to go a long way from our original psychoanalytic framework and have expanded it to include concepts taken from clinical psychiatry, developmental and experimental psychology and from neurophysiology. Such an eclectic approach seems to us to be demanded by a subject which lies at the focal point of many disciplines.

Finally we should like to emphasize the value of careful clinical observation in any study of schizophrenic patients. Although we propose to complement our clinical findings with information obtained by experimental methods we do not mean to imply that the latter type of data is necessarily more objective and 'respectable', or that upon it depends the validity of the clinical material. Clinical observations may provide their own internal criterion of validity, *if* they are made in a controlled and systematic way. We are well aware that the observations upon which the present paper is founded have been collected in a manner which does not comply with these conditions. They have, however, led to the formulation of a hypothesis which can be subjected to a more rigorous evaluation. It is our hope that the reporting of the observations made by these patients will serve to accentuate the primary role which clinical observation must play in the development of any constructive theory of schizophrenia.

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The non-psychotic residue in schizophrenia

By JAMES M. DAVIE AND THOMAS FREEMAN*

The most superficial acquaintance with schizophrenic reactions reveals that the disease process does not involve the entirety of the patient's mental life. In some cases so many psychical activities remain intact that the observer is left with the impression that there is little evidence of a major mental illness. In other cases, however, there appears to be a disintegration of all those mental processes which are necessary for environmental adaptation. However, even in cases like this some indication of normal mental functioning makes its appearance from time to time. The literature on schizophrenia provides many instances of this phenomenon—for example, the case is quoted of a deteriorated patient whose incoherent utterances generally consisted of a stream of obscenities. When she was asked why she used these particular obscenities, her reply was 'Don't use swear words in my presence' (Freeman, Cameron & McGhie, 1958). Observations of this kind present the observer with a fundamental problem. He must consider whether there remains, even in the most deteriorated patient, a non-psychotic complex (for want of a better term) which hides behind the manifest dementia or whether he is confronted with an entirely different process which leads to the observable phenomena.

The purpose of this paper is to examine what we would like to describe as the non-psychotic residues in schizophrenic states. We prefer to avoid such terms as 'non-psychotic layer' (Katan, 1954), and 'non-psychotic part' (Bion, 1957) because of their association with a predominantly topographical and structural conception of mental functioning. Such a conception often has the consequence

of turning interest away from what we like to think of as the fundamental problem of psychotic illness—namely the manner in which mental processes are affected by the disease. For us the term 'non-psychotic residues' refers to mental processes which are not directly involved by the psychosis. It equally refers to the contents by which these processes achieve mental representation. This concept of non-psychotic residue suggests that once those mental processes which have been affected by the disease have been isolated—or precipitated, to use a chemical analogy—what remains must be thought of as essentially non-psychotic. It is this hypothesis which we now wish to elaborate with the help of clinical observations obtained during the treatment of patients.

We have learned from psycho-analysis that these mental processes which enable the individual to satisfy his basic needs and which also serve social adaptation can be thought of as functions of a mental organization which Freud (1923) named the ego. This concept of '... a coherent organization of mental processes...' (Freud, 1923) differentiates the aforementioned psychical processes from those which are characteristic of the id—that is, those which obey the laws of the primary process (Freud, 1900). In terms of this conceptual framework schizophrenic states have been described as conditions resulting from injury to the mental organization (ego). It is consistent with this view to identify the non-psychotic residues in such states as those ego functions which have escaped involvement by the psychotic disturbance. In this respect the defensive and synthetic functions of the ego must be accorded an importance equal to those of attention, self-awareness, thinking, perceiving, memory and control of motility.

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FLUCTUATIONS IN THE FUNCTIONAL LEVEL OF COGNITIVE PROCESSES

Disturbances of cognitive processes are commonplace in schizophrenia. Thinking, perceiving, attending and remembering suffer to varying degrees, and manifestations of the disturbances can be observed during the most casual clinical contact. The situation is somewhat different whenever patients participate in a continuous psychotherapeutic relationship. Here an excellent opportunity is provided for the witnessing of the ebb and flow of the pressure which the psychotic process exerts upon these cognitive functions. It is under such circumstances that the non-psychotic residue can be most effectively studied. Let us first consider verbal communication. Apart from the physiological mechanisms involved in speech the efficient performance of this function is dependent upon the integrity of verbal (conceptual) thought and upon the capacity to perceive such thoughts. This latter process is an aspect of a much wider function which Rapaport (1951) has termed reflective awareness. In the following clinical illustrations we can observe the manner in which directed verbal communication is dependent upon the functional level of these mental processes. They will show that the emergence or disappearance of non-psychotic communication is determined by changes which affect both reflective awareness and the capacity for conceptual thought.

I

In this first example we are presented with the transition from well ordered to nonsensical and inappropriate verbal communication. The patient, a young man of 26, had been told that his treatment sessions were to be stopped for a few days. When he asked why, he was informed that his doctor had to go to Hull. He replied as follows: 'Do not say you will not come until Tuesday, will you not come tomorrow? Do not go to Hull...'. At this point the patient's utterances became confused and incoherent. The content, as far as it could be

followed, consisted of references to a school friend called Hull who had hurt himself and to a play in which the patient participated and in which he had to take a leap (presumably through a window). This play which had both a religious and demoniacal content had a special significance with regard to the time of onset of the patient's illness.

The same patient provides us with our second example. Again it occurred against the background of an impending interruption of treatment. Here we are confronted with the change from disconnected and barely intelligible utterances to communications which are both coherent and comprehensible—both series being concerned with the same content. On this occasion the therapist was five minutes late arriving in the ward. The patient was apparently unperturbed by this. He examined his face in the mirror and made some inaudible comments about his chin. He then said that his 'Lazy Shave' (the name of his shaving cream) cost 8s. He wanted to know if he should use it. Three times he said 'I have something to report...' but could proceed no further. He smiled inappropriately and laughed. As he was so quiet the question of the break in treatment was mentioned again but he met this with silence.

When the session was over the therapist stopped to speak to an attendant in the ward. Another patient interrupted this conversation while our patient stood by listening. After some minutes he burst out in a fit of fury—'You came late, bugger off—what do you think this place is'. This was followed by utterances which made little sense. However, shortly after he screamed at the therapist—did he not know that he had been in the hospital for five years and that he had never had a holiday. His chin had been cut by an attendant while being shaved—the razor blade had been dirty and his tin of shaving cream which cost 8s. had been taken away from him. At this he stamped off. Later in the day he had reverted to his previous state of affective indifference.

For a few moments this patient regained the

capacity to reflect upon himself and upon his unhappy predicament. He was able to communicate his discontents and his utterances were no longer characteristic of the primary process. The restoration of mental activities to a level which can be described as non-psychotic must occur contemporaneously with the recovery of the ego. This recovery was reflected in the re-emergence of self-awareness. The transition from the abnormal to the normal must result from decisive changes in the psychic economy along lines similar to those developed by Freud (1900) in his account of the primary and secondary processes. In our first example, the patient lost his ability to direct his thoughts for the purposes of rational communication. From the moment he mentioned Hull his thoughts followed association paths which would have been immediately rejected by an intact ego. As Freud (1900) points out the direction which thinking takes under the influence of the primary process is one which is determined by the sensory vividness of the ideational material—the outcome of condensation. At the same time the break between the verbal symbol and the object or the idea symbolized promotes an ambiguity in verbal expression. A single word can act as a signpost directing associations in entirely different directions. For example, a female schizophrenic patient said 'My husband is waiting for me at the Grand Hotel'. 'He is stabilized—not like a horse. He is a diabetic'. It is at this point that we can assume with some justification that the factors which are responsible for the dream work (the process whereby the latent dream thoughts are converted into the manifest dream content)—namely, displacement, condensation and considerations of representability—are equally responsible for the form which mental processes take in schizophrenic states.

Rapaport (1951) contends that an association exists between the loss of self-awareness and the emergence of the primary process. Both phenomena may be thought of as aspects of a special state of consciousness qualitatively

distinct from that of the healthy adult. This view is supported by such clinical observations as the following. The patient to whom we have already referred began talking about Klaus Fuchs, the atom spy. Our patient pronounced the name 'claus'. He said: 'Klaus Fuchs had a cheek giving away the atomic secrets. He might have destroyed Christmas and Santa Claus'. A second or two later he shouted out 'I need Santa Claus'. When the session ended some ten minutes later he asked: 'What was it we were saying about Klaus Fuchs?' Evidently he had no recollection of what he had said. Only at the end of the time did some degree of reflective awareness return and was he able to communicate coherently.

II

We would now like to conclude this section of the paper on cognitive processes by referring to the fluctuations in the constancy and stability of visual percepts which may occur in schizophrenic states. In a previous report (Davie & Freeman, 1960) a detailed account was given of the form which these fluctuations take. In one case—a young schizophrenic woman—the disturbances were most often associated with affects which were aroused by the treatment situation. In another case it was impossible to discern the stimulus for these subjective reactions and in yet another case the abnormalities were closely linked with movement. As with verbal communication we observe the loss and return of mental processes indispensable for environmental adaptation. These observations suggest once again that the concept of 'non-psychotic' must be freed from undue topographical significance. It should be thought of as describing the means whereby mental processes emerge from a state of primitivization or dedifferentiation as a consequence of some alteration in psychic economy. Certainly the clinical data recorded here are yet another demonstration of the value of regarding schizophrenic states as functional psychoses.

UNCONSCIOUS CONFLICT
AND SCHIZOPHRENIC PHENOMENA

We are accustomed to think of psychoneurotic symptoms as the outcome of the defensive functions of the ego. They are compromise formations and have an adaptational function. In schizophrenic states, on the other hand, we assume that the symptoms are the outcome of a breakdown of defence especially of the counter-cathetic function. Counter-cathexis is a basic function regulating the entry into consciousness of primary process mechanisms. At the same time it acts as a stimulus barrier with respect to the environment thus guaranteeing the intergity of those mental processes which are necessary for environmental adaptation.

It may be argued that schizophrenic symptoms are the outcome of a defence initiated by regression; however, even if this is true these symptoms differ from those of the neuroses in that they are essentially non-adaptational. Our findings confirm the theory that the role of unconscious conflict is of paramount importance in the formation of schizophrenic symptoms. However, we believe that these conflicts are not essentially different from those encountered in the neuroses. While they act as precipitants of schizophrenia they do not form an indispensable component of it. Nevertheless, they may colour or modify the psychotic symptoms and indeed may determine their content.

I

Our first illustrative case is that of a 21-year-old hebephrenic girl who, during one of her sessions, was talking about her need to feel safe. While reporting some adolescent sexual experiences with a boy she said she could no longer think. It was like that at the beginning of her illness when she felt that her mind had broken and she found herself reacting to everyone with sexual feelings. These feelings were followed by violent hatred. It was all feeling, no thinking. She felt there was nothing of her left. There were many similar incidents

in the first two months of therapy. During this phase the sexualized transference reflected her current relationships outside of treatment. The catastrophic regression with resultant loss of secondary process thinking was precipitated by her castration anxiety made unbearable by the unusual intensity of her penis envy and reinforced by accidents of fate.

Important experiences in her early history had included the absence of her father during her first five years. Throughout this period she had slept with her mother but was suddenly ousted on the father's return from the war. At the age of eight she had a spell of six weeks in a fever hospital which coincided with the birth of a dead male child. At the age of twelve her father had died following a painful spinal illness. Thus her oedipal wishes had led in her phantasy to the death of both father and brother. Erotic feelings, for her, were invariably accompanied with extreme castration anxiety already re-enforced by the realization of her death wishes.

Besides the inability to think in the treatment sessions she frequently reported visual hallucinations. In one interview she was speaking quite rationally about some of her friends and relatives—Margaret, her sister, with her husband; Moira, her friend, with her baby and new house; and then she spoke about Dr R. and Dr H.—how lucky they were! they had freedom, they had cars—and then she stopped and said she saw a pipe on the wall as if it were projected on a blank screen. This then changed into a wide circle. When asked to talk about it she described the pipe as Andrew's, a boy with whom she had some masturbatory activity just prior to her breakdown, and the circle as a sanitary napkin she had seen in her mother's room as a child. These associations were relevant to the circumstances of her initial breakdown about two and a half years earlier. At the time of onset of the illness she had been training as a nurse and had to live in the nurses' home. She described the anxiety she felt when on occasion she shared a room with other girls. Currently with this she found herself compulsively falling in love with many

of the medical students and young doctors, one of whom was Andrew. The actual breakdown followed a gynaecological examination for the investigation of amenorrhoea of several months duration. At first she felt that her colleagues were laughing at her, and then, as she reported, her mind broke and she was unable to think. On admission to hospital she was described as displaying thought blocking and evidence of hallucinations but she herself said that for one night she was blissfully happy. She felt something growing up right through her head and for the first time she had felt complete.

At times the content of her thought was in terms of castration anxiety. She was unable to think, she would make stupid mistakes—going up the wrong stairs or not knowing where she was. They were all laughing at her because she had an empty head, its top was sliced off. In therapy she described feelings about the doctor's head—she wished she had his brain and could think like him. She laughed and said she supposed he'd say penis. This was immediately followed by a panic reaction and a visual upset. She said that his face was changing in shape and turning white and there was a spirit beside it. Later in the hour, she described her reactions of anger and disgust when she had handled Andrew's penis just prior to her breakdown. This was associated with a childhood encounter. She had told a small boy, when watching him urinate, that hers was there too, but it would grow. It is clear that this patient's visual hallucinations and thought disturbance were provoked principally by her penis envy and castration anxiety. The homosexual conflict hinted at in her uneasiness about the rooming situation on the other hand, gave rise to a different set of symptoms—namely, auditory hallucinations and feelings of merging with other women. She described how another patient spoke to her whenever she saw her, even at a distance of a quarter of a mile—how her voice referred to her homosexual play with her sister and how odd she was because she did not menstruate. The voice would then go with her back to the

ward. On one occasion she thought this woman had changed into a man in front of her eyes and there were times when she felt she was joined to her.

II

The association between homosexual conflict and schizophrenic symptoms was also to be found in our second case—a 34-year-old paranoid schizophrenic male. When first seen he had been in Mental Hospital for about two and a half years. He was regarded as dangerous because of his frequent assaults on other patients and occasionally on the nursing staff. Only after some months of psychotherapeutic contact did it become clear that following upon unconscious homosexual arousal he experienced a merging sensation with the man who was the object of his homosexual libido. The content of his homosexual phantasy consisted of the idea of being penetrated in intercourse. Later he said that he thought of himself as Erica (his name was Eric). His thought would be answered by the other man saying 'yes you are' and the latter would then suggest that they merge. This would be followed by feelings of being fused with the other man. It was then that he had to attack the man in order to preserve his individuality—so that he could feel separate. For our patient homosexual feelings meant losing the penis and being turned into a woman. At first the only complaint he was able to make about other men was that they used his name. This was he said, the same as using him and later he added abusing him. To take his name was to take his penis. Unlike the girl he was unaware of homosexual feelings. Only after six months of treatment was he able to recognize transient homosexual inclinations.

The homosexual conflict screened castration anxiety. It was this anxiety which precipitated regression to a state not unlike that of primary identification with the loss of body boundaries and a feeling of merging with other men. We must distinguish this actual sensation of merging from the phantasy of homosexual intercourse. This phantasy activated castration

anxiety which in turn led to a massive regression with withdrawal of cathexes from both objects and self-representations including the body boundaries.

III

The role of homosexual conflict and castration fear in the initiation of the psychotic process was to be observed once again in a young student of 21. At the time of his breakdown, he was preparing for examinations and having sexual difficulties with a girl friend. The first psychotic symptom had been the delusion that there was something wrong with his penis. This was followed by complaints that a friend was making accusations about him and that the police were having him watched. At the time of his admission to mental hospital he was in a state of complete confusion with a loss of self-awareness and identity—for example, he would get into the wrong bed or try and wear other patient's clothes. In the following three months, the schizophrenic symptoms completely disappeared. In the course of this recovery, the disturbances of his body were modified, transformed and represented through the medium of his adolescent prepsychotic conflicts. The core of the psychotic state could be thought of as due to disturbances of the body and its boundaries resulting once again from an ego regression with concomitant withdrawal of cathexes from object representations. The other psychotic symptoms—feelings of being influenced, ideas of reference, paranoid delusions—could all be viewed as modifications of the primary disturbance undertaken by the synthetic function—a function which can in this case be considered as independent of the psychotic process.

In the initial interview he showed the same confusion that he showed in the wards. He was unable to differentiate himself from his therapist. Only gradually was contact made, first, through his ability to recognize in an electrical fitting in the room something he understood and knew about, and second, through a barometer outside the treatment

room which reminded him of a barometer at home. At that time the symbolism of the objects was ignored, the therapist merely pointing out how reassuring it must be for him in the midst of so much confusion, to be able to talk about something he was sure of. This enabled a meaningful contact to be established and there was a marked improvement in his behaviour in the ward.

He then complained about a system which was controlling him from the therapist's consulting room—a system of hidden microphones which gave out voices, the therapist's voice telling him what to do but at the same time spying on him. In this he still felt merged with the therapist but the merging feeling was now rationalized into a more complex technical system, one which he was more likely to understand since he was a student of electrical engineering. His associations at that time showed that he was terrified lest the therapist was a homosexual or that he would think that the patient was a homosexual. Homosexual meant having no penis and being a woman. He invited the therapist to examine his penis to show him that he was not homosexual. He also wanted his skull examined to see why his brain was not working—why he could not think properly. The thinking disorder was expressed in terms of castration anxiety which itself was the means whereby he found a psychical expression for his anxieties and confusion about his body boundaries. At times he felt his penis was withering away or had disappeared. Memories of adolescence and childhood indicated that he had considerable homosexual conflict. Following the death of his father, at the age of twelve, he had violent crushes on a number of athletic coaches. He admired and wanted to emulate them, but, at the same time, he felt very frightened of them.

This patient's fear of annihilation—of being merged in the other person—were now transformed and expressed in terms of his prepsychotic homosexual conflicts. The precipitation of the illness can be traced to castration fear which had one source in the sexualization of his studies. His choice of engineering as a

profession had as an unconscious determinant the need to overcome the fear that mechanisms need not operate properly. Childhood reminiscences provided ample proof of this need. As his examinations approached he had tried to find reassurance about his genitality from a heterosexual relationship. It is not unreasonable to assume that the breakdown occurred because this undertaking did not allay the mounting castration fear.

IV

We have presented this material to demonstrate the type of unconscious conflicts which may precipitate a schizophrenic state and which continue actively during the illness. As our clinical examples show these conflicts can provoke new symptoms under appropriate conditions. It is unnecessary to think of these conflicts as central for the psychotic process. In our view they are not specific for schizophrenia and they must be differentiated from the primary psychotic mechanisms to which they are peripheral. These non-psychotic conflicts not only act as precipitants but they provide the ideational material whereby the psychotic process—with its loss of individuality and merging—can find some form of mental representation. This is the work of the synthetic function of the ego. The outcome is the conversion of feelings, thoughts, and sensations, which are terrifying for the patient into a psychological complex—the psychotic reality—which provides a 'rational' explanation for the subjective experiences. One of our patients, for example, utilized his pre-psychotic oedipal conflicts which had been expressed in religious terms to provide a means whereby he could explain the disturbances which the schizophrenic process caused in his perception of his body and the environment.

VARIATIONS IN TRANSFERENCE MANIFESTATIONS

We would like to preface our observations and comments on this important topic by stating briefly what we understand by the con-

cept of transference. We subscribe to the view, comprehensively represented by Glover (1955) that a distinction should be made between phenomena due to transference and the specific set of psychological reactions which represent the transference neurosis. In the case of the former we observe the displacement on to the therapist of reactions which are derived from affectively significant individuals in the patient's current life or from his recent past. A woman patient, for example, may keep the analyst waiting as she does her husband. Glover (1955) refers to this type of phenomenon as one kind of 'floating' transference. It by no means follows that 'floating' transferences will gradually give way to a transference neurosis. The latter is the result of the repetition in the present of the object relations of early childhood now experienced in relation to the analyst. While the development of the transference neurosis is a spontaneous outcome of the analytical situation it is not an immediate response to it. Glover (1955) makes the important qualification that the occurrence of a transference neurosis is not an invariable manifestation in the psychoanalysis of the neuroses.

When a transference neurosis develops in the course of the psychoanalytic treatment we regard it as the outcome of an ego regression of the temporal type (Freud, 1914). This regression which affects only certain ego functions is induced by the two unique conditions of the analytical situation—namely, free association and the recumbent position. An essential requirement for the successful management of a transference neurosis is the continued presence within the patient of a self-awareness which notes the effects of the regression and can co-operate with the analyst in working through the revived childhood conflicts. It is at this point that we may inquire into the kind of transference manifestations which occur during the psychotherapy of schizophrenic states as it is precisely in these conditions that the faculty of self-awareness is impaired. We must consider how far we can compare these manifestations with the transference neuroses as

they are to be found in the psycho-analysis of neurotic disorders. The situation is complicated still further by our knowledge that amongst other consequences the disease leads not only to the regressive processes which affect the ego but to a regression of the instinctual drives also.

I

The psychoanalytic study of case material, particularly in the sphere of transference, comprises both the recording of clinical data and its interpretation. It is the interpretation which so often gives rise to controversy. Psychoanalysts are frequently thought of as credulous in that their inferences are based upon what appears to be insufficient evidence. For this reason we have endeavoured to limit our interpretations to well-established constellations of clinical phenomena as they have appeared in the course of therapy. We have rejected the technique of immediate interpretation following upon the ephemeral appearance of some particular utterance or behavioural phenomenon.

The first case which we would like to describe is that of the young female schizophrenic to whom we have previously referred. She entered treatment in a state of cognitive deterioration and affective instability. However, even in the early days of therapy she was able to dissociate herself to some degree from her subjective experiences and report them in her associations. Thus far the patient behaved very like a case of hysteria where the resistance results from unconscious transference phantasies with a sexual content. The presence of this material and the undoubted schizophrenic manifestations led us to suspect that we were dealing with two qualitatively different kinds of transference material, one springing from what can only be described as the non-psychotic part of the ego and the other a manifestation of the psychotic disturbance within the ego. The latter consisted of hallucinatory phenomena centring on the therapist and of a difficulty of defining him as a separate individual *vis-à-vis* herself.

Gradually floating transferences of the type Glover (1955) describes appeared first with respect to the father and then to the mother. In both instances these transferences reflected a positive relationship to the therapist and the need to have him as a protector against genital arousal. This material slowly gave way to what must be described as a transference neurosis the content of which consisted of the conflicts which existed between her mother and herself. The path to this phase was by way of the castration complex and the recall of sexual games with her sister. She dreamt immediately prior to a break in the treatment that: 'She was hugging her father around his waist and he fed her with porridge. Her face was where his nipples were and he was telling her that when she was small her mother loved her a lot'. This dream threw light on the form the sexual games had taken with her sister. It was also followed by the information that she had lived alone with her mother until she was five years old and had shared her bed. The patient began to feel that the therapist had similar traits of character to her mother. During this period there were periodic occurrences of psychotic manifestations within the transference situation of the type referred to above.

II

The second case is somewhat different. He is the paranoid schizophrenic man who has already been referred to in another context. We have already described how this man was given to assaulting other patients if he thought they were mentioning his name and how we came to understand that this concern about his name was associated with a loss of his body boundaries. He entered into the treatment situation without much difficulty and within a short time signs of transference appeared—the therapist was identified with the patient's brother who was a doctor. Anxieties springing from an unconscious homosexual transference were plentiful and their form and context did not differ from what is encountered in the treatment of a neurosis. Derivatives of these

anxieties consisted of an undue apprehension about the nature of the treatment and a distrust of doctors.

Within a few weeks of commencement the patient's reactions took a new direction. He became rather more suspicious during the interviews and he began to attack other patients. It was about this time that he indicated that his concern about his name screened the terror of loss of identity and the sensation of merging with another man. Within a matter of days he reported that he had become aware, to a slight degree, of the merging feeling in the treatment. Several weeks later he announced that he had the impression that the therapist was calling him Ericle—little Erica. Coincidental with these revelations he again began attacking other patients whom he accused of calling him by these names.

Only the constant discussion of his fear that he would merge with the therapist, lose his masculinity and be degraded into womanhood enabled him to express his psychotic experiences, now wholly concerned with the therapist, rather than commit acts of violence in the treatment room. He hallucinated that the therapist was calling him 'yellow', telling him that he was going to die, that he was 'a little dear'. These phenomena were always accompanied by the merging sensations. At this stage of the treatment the 'neurotic' transference manifestations which were present initially had faded completely into the background. Unlike the woman patient at a similar stage in treatment there was nothing which could be likened to a transference neurosis.

III

The third case which we would like to describe is that of the young man whose utterances formed the major portion of the first section of this paper. His condition was utterly unlike either of the other two patients. He showed little interest in the initiation of regular meetings and most of his talk was either illogical or incomprehensible. He appeared to have no reaction to the therapist's

presence. He forgot appointments and did not know the therapist's name. However, there were occasions, even in the midst of extreme negativism and withdrawal, when he would suddenly express himself logically. One day he said at the end of a session, 'I hope I have not been rude'. There were references to teachers, relatives and friends which might have been a reflexion of transference manifestations but the fragmented nature of his communications prevented the confirmation of such a hypothesis. Periodically he hummed and sang songs which could again have been in the nature of references to the therapist.

It was not, however, until the first interruption in treatment that he showed an affective reaction which was clearly related to the therapist. This was the occasion when he asked the latter not to go to Hull. During the ensuing months there was no evidence of a transference beyond the fact that he seemed willing to describe some of his delusional ideas and bodily experiences. When the interruption for the summer was announced he reacted violently in the manner detailed above. There could be no doubting the presence of an affective tie between patient and doctor. That this was in the nature of a transference was confirmed first by the report that during the break he had said that the therapist was not away because he had not taken his children, and second by the fact that his first announcement after the break was to tell where his parents had been for their summer holiday. We may recall that he had complained bitterly that he had not had a holiday for five years. It seemed reasonable to assume that for the first time the patient had expressed affects in the therapeutic situation which were derived from the parental relationship.

The resumption of treatment saw considerable improvement in his condition. His utterances became more frequent and intelligible. He enjoyed the sessions and looked forward to them. At this time the treatment relationship was characterized by his obvious and pressing need to communicate. It was during this phase that he reported a strange experience. At first

he described it as happening some years previously but later he located it in the present. A man had approached him in hospital—he thought he was an atomic scientist—something (he pointed to his penis) had passed into him and was still there. Later he said more coherently that a man had tried to interfere with him. We were not inclined to regard this experience as reflecting a current homosexual transference which was a source of anxiety to him. We adopted this view because of the patient's continued positive attitude to the treatment. It seemed much more likely, at this stage, that he found the relationship with the therapist one of safety. One in which he found security not only from his phantasies but also from the real dangers which sprang from the behaviour of other patients.

IV

In these examples we have shown how the frequency of non-psychotic transference manifestations—that is ones not unlike those which are to be encountered in the psychoanalysis of the neuroses—will depend upon the extent to which the ego functions remain intact and upon the degree to which the libido can still effect object cathexes. In the first patient the non-psychotic transferences were considerable in their development and they were associated with the capacity for the libidinal cathexis of objects and with minimal damage to the ego organization. In the second and third cases we observe progressive damage to the ego functions and to the capacity for object cathexis with a concurrent diminution of non-psychotic transference phenomena.

SUMMARY

In this paper we have described clinical phenomena to support the theory that a sharp distinction should be drawn between psychotic and non-psychotic processes. The former con-

sists of a de-differentiating sequence which may effect every ego function and the capacity for object cathexis. The simultaneous appearance of the primary process gives many schizophrenic manifestations their characteristic stamp. It is the activity of this primitive mode of mental functioning which is the common factor to dreams, jokes and schizophrenic communications.

First amongst the non-psychotic processes are the unconscious conflicts which initiate the illness and which remain active during the course of the disease. We have tried to show how the content of these conflicts provides the ideational material for the preconscious representation of the psychotic process. This reorganization is undertaken by the synthetic function of the ego. It is worth recalling that in severely deteriorated schizophrenic states there is no indication whatever of a delusional system. In such cases we can assume that the synthetic function is in abeyance along with the other activities of the ego. Sometimes psychotherapeutic work can restore the ego to a state where the synthetic function can again re-organize the fragmented psychotic processes in the terms of a pre-psychotic conflict.

The degree to which other ego functions will remain non-psychotic will depend upon the ramifications of the psychosis. As this extends the non-psychotic phenomena will diminish in frequency but they will return again with the weakening of the psychotic influence. It has been our experience that the same occurs in the sphere of transference. As long as the psychosis is limited in its effect upon the ego and upon the capacity for object cathexis transferences will occur not unlike those in the neuroses. If, however, the psychosis widens its field then psychotic manifestations increasingly make their appearance in the treatment situation. Only as the psychotic process withdraws does the doctor-patient relationship again assume a similarity to that encountered in the treatment of the neuroses.

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The Sources of the Anxiety in Paranoid Schizophrenia

By HAROLD F. SEARLES*

In this description of what I have found to be the major sources of anxiety in individuals suffering from paranoid schizophrenia, I shall endeavour to demonstrate how affective phenomena and structural phenomena are interrelated. Further, although I shall have to assume, during much of this portrayal, the vantage point of the observer, whenever possible I shall discuss these sources of anxiety in terms of the patient's own subjective experience of them. This latter emphasis helps to explain the apparent paradox that I shall count, among the 'sources' of his anxiety, various *ego-defensive* phenomena. We well know that to any psychiatric patient himself, the threatening affects present themselves not undistortedly as such, but in forms modified by ego-defences which, although intendedly protective, at the same time distort his experience in a strange and frightening way.

One point I wish to make at the outset is that the paranoid individual seems rarely, if ever—except perhaps in states of panic—to feel anxiety as such. I have come to believe it pathognomonic of him that he experiences, instead, an awareness of various ingredients of his surroundings—or, less often, of things within his body—as being charged with sinister meaning, charged with malevolence toward himself. A simple example of this is to be seen in the reaction of a woman to a new room to which she had been moved, after her having spent many months in a room upstairs in the same small building. Whereas I found myself feeling, in our first interview in this new

room of hers, a fair amount of anxiety which I related to the unfamiliarity of these new surroundings, she seemed entirely unaware of any such anxiety, and flatly disclaimed, when I inquired, that she felt so. She asserted that a woman has no such feelings, that a woman likes to move around and, in fact, has to, in order to keep alive. What she voiced, instead, was a threatened kind of conviction that the water in this new bathroom tasted sinister; she mentioned uneasily that some wine which a nurse had given her today tasted like 'mahogany'; and she said that she did not like being down near the earth, indicating that this would make her more vulnerable to being turned, by 'them', into a tree.

Freud (1911), in his discussion of the Schreber case, described repressed homosexual desires as being at the root of the paranoid patient's preoccupation with the persecutory figure or figures. It seems to me a more adequate explanation to think of the persecutory figure as emerging into the forefront of the patient's concern, not primarily because of repressed homosexual interest on the latter's part, but rather because the persecutory figure is that one, among all the people in the patient's current life-situation, who most readily lends himself to reflecting, or personifying, those qualities which the patient is having most vigorously to repudiate in himself and project on to the outer world. Whereas he is convinced that the persecutory figure is pursuing him—in one fashion or another pressing threateningly upon him—we find, in the course of his psychotherapy, that the state of affairs actually consists, basically, in the circumstance that his own unconscious feelings and attitudes, projected upon that other person, are pressing for awareness and acceptance into his conscious conception of himself.

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He finds himself unable to renounce any concern with that other person, and reach a state of peace about the matter, for in actuality this would be tantamount to repudiating important components of himself; moreover, the other person is necessary to him as the bearer of these externalized (i.e. projected) emotions. But, on the other hand, he cannot find peace through a friendly acceptance of the persecutory figure, for this would be tantamount to accepting, into his own picture of himself, various qualities abhorrent to him. So an uneasy equilibrium is maintained, with his experiencing a gnawing, threatened, absorbing concern with the persecutory figure whom he cannot rid from his mind.

One sees this mechanism particularly clearly in those patients whose projections attach not to any real-life figure at all, but to a quite pure-culture *alter ego*. One such patient had changed his name, at the age of twelve, from John Costello to John Cousteau, evidently in an attempt to establish an identity more acceptable to himself. He came into one particular session, early in my work with him at a VA clinic years ago, shaking and perspiring visibly, and described how furious it had made him, a few days before, when at a pension examination the secretary had mistakenly called out his name as 'John Costello'. He became very worked up as he described this, saying: 'I don't like John Costello—he was a selfish stinker . . . the name sticks in my throat.' A woman who for years had the delusion that she had 'doubles' to whom she attributed all the feelings, attitudes, and behavioural acts which she had to repudiate from her concept of herself, came, in the course of our sessions, to express intense hatred of these 'doubles'. She said: 'I wish they'd fry. Somebody ought to shoot them. They're chisellers.' I commented, 'You seem to hate them at least as much as you hate psychiatrists', and she agreed. I went on: 'You seem to feel that the doubles are as much your enemy as the psychiatrists are.' She replied, vehemently: 'They [i.e. the doubles] are the enemy.'

Conspicuous as the defence-mechanism of

projection is in paranoid schizophrenia, I have come to believe that the complementary defence, introjection, while less easily detectible, is hardly less important. The patient lives chronically under the threat, that is, not only of persecutory figures experienced as part of the *outer* world, but also under that of *introjects* which he carries about, largely unbeknown to himself, within him. These are distorted representations of people which belong, properly speaking, to the world outside the confines of his ego, but which he experiences—in so far as he becomes aware of their presence—as having invaded his self. These, existing as foreign bodies in his personality, infringe upon and diminish the area of what might be thought of as his own self—an area being kept small, also, by the draining off, into the outer world, through projection, of much affect and ideation which belongs to his self.

In the course of his psychotherapy one comes to see the extent to which these introjects threaten the self with total abolition. One woman came to express it, after many months of therapy: 'Why, I'm not even myself! . . . Those people are in my bowels and in my stomach and in my heart! . . .' On another occasion she said, with urgent anxiety: '*Who am I?* I don't have any *identity*.' For several months, when an introject of a constellation of qualities traceable to her mother held sway, she showed every indication of assuming herself to be her mother, and spoke of her siblings as 'my children'. One patient came to experience herself as a 'baggage car'; another as 'Noah's ark'. Still another experienced herself as a Trojan horse filled with a hundred people; and a man portrayed in a dream his own state of being filled with introjects: he dreamt of a man with a belly so enormous that he could scarcely move about.

A woman met me as I walked toward her building, for a therapeutic session with her, and in great agitation showed me a page in a story she was trying to read, a page on which the protagonist, 'I', was describing a conversation involving several participants. She said:

'Four men and a girl—which one is "I"?—There's William and George and Peter—maybe Peter is "I"... Which one is "I"? And as we walked into the building she said: 'You've got too many people here, Dr Searles... I get overwhelmed by people.' She had recently been expressing a wish to 'push people away', and would say of this or that nurse or fellow-patient, 'she reminds me of several different people'. This woman, so close to a hebephrenic state involving the loss of any continuous sense of personal identity, was attributing to these other persons her own state of personality-organization, namely that of, as one patient phrased it, a 'composite personality', comprised largely of introjects.

I have found repeatedly that the individual with paranoid schizophrenia, initially so unwaveringly certain about everything, and never doubting that his views are his very own, reaches, after years of intensive psychotherapy, a point where it becomes clear not only to the therapist, but to himself also, that nearly everything he has been saying is in actuality but an ill-understood hodge-podge of the parroted—though unwittingly caricatured and otherwise distorted—utterances of his parents and other significant persons from his childhood. He comes to reveal, at long last, precisely the confusion of a small child who has been exposed to a bewildering cacophony of parental statements and who has not found, heretofore, anyone sufficiently trustworthy and patient to help him find his way out of his confusion. Two among the patients who have reached this point, in our work together, have come to say, quite simply and seriously and trustingly, 'I don't know anything'.

Inevitably, on the path to the establishment of such a degree of trust and openness in the transference-relationship, there will be many periods when the anxiety in both participants will far exceed any mutual security they have been able to find together as yet. During these periods the unintegrated welter of emotions, memories, fantasies, somatic sensations and other perceptions, initially contained within the patient's rigidly formulated delusions, will

emerge, with the result that his personality-functioning becomes chaotically fragmented—so much so, oftentimes, as to constitute a formidable threat to the therapist's own personality-organization. At such times the therapist can see to what a degree the patient's delusional formulation of his life has served as a substitute for any genuine and healthy sense of a pattern in living. The paranoid patient is not sufficiently in tune with his fellow-men; not sufficiently able to integrate the ever-flowing nature of life with its concomitants of change and growth, fulfilment and loss, birth and death; not sufficiently matured in his thought-processes to be able to distinguish the more significant from the less significant incidents and threads in his life; and not sufficiently loving and trusting to experience love as the ingredient which gives human existence cohesiveness and meaning; to be able to feel the wholeness, the genuine 'master plan', which the healthy individual comes to see in his life. I like to compare the description, in Noyes's (1951) text-book, of the process of retrospective falsification in paranoia, with the healthy realization of a true pattern in his life which the neurotic patient achieves in the later phases of a successful psychoanalysis: 'Incidents of the past receive a new interpretation and he discovers in them a significance which was not recognized when they occurred....'

The fragmentation to which I refer is not different in kind from that seen in hebephrenia. Markedly varying moods, and widely disparate levels of ego-organization, may appear in rapidly changing and random sequence. The individual's perception of the world about him is jumbled up with hallucinatory phenomena and with vivid perceptions of scenes from his past. He may experience not only other people but also himself as being unwhole, a composite of bodily fragments of persons from both current life and bygone years. He may be incapable of sequential thought and speech, and may hear only fragments of what the therapist says to him. One such patient, who at the beginning of our work had shown, for years, the rigid overcontrol of

feeling so characteristic of paranoid schizophrenia, through many months of fragmentation in which, for example, she would bellow at one moment that we criminals should kill her and thus end her torture, and at the next moment would be laughing warmly; would at one moment be a monumentally arrogant woman and, the next moment, a touchingly childlike creature; and, at times when I overestimated her capacity to share an informal friendliness in our sessions, she would become overwhelmed by deeply ambivalent feelings traceable eventually to her relationship with her mother. Following one such therapeutic hour, she became savagely combative and, when the nurses were putting her into a cold wet sheet pack, she bit the breast of one of them; but only a short time later, while still in the pack, she asked another for a kiss, and this nurse, touched by this childlike request which the patient had never before made, gave her one. Her moods with me would change equally rapidly, and I can only mention in passing, here, the extreme fragmentation which occurred not only in her affective experience, but in all areas of her perceptual functioning, including that having to do with her body-image, before a healthy reintegration became established.

I find it helpful to think of this phase of fragmentation not simply under the global heading of regression—which is, indeed, one way of characterizing it—but, more specifically, as a reversal of the normal growth process of integration-and-differentiation (Searles, 1959*b, c*). That is, we can see normal growth, psychological as well as biological growth, to be a process of integration of previously separated *anlagen* into coherent functional structures, and, concomitantly, differentiation of functional structures into more complex patterning which provides for an increasingly wide range of discriminations and specializations of functioning. In the phase of fragmentation which I have been describing, there are phenomena not only of disintegration but also of dedifferentiation, a term introduced by Heinz Hartmann (1939) to describe the loss of

already differentiated psychological functions which we find in states of regression, particularly in schizophrenia. The comparative psychologist, Heinz Werner (1940), who introduced this term independently, illuminatingly compares the states of de-differentiation seen in schizophrenia and in brain injury, with the ego-functioning found in children and in members of so-called primitive cultures, as well as with the modes of sensory functioning found among a wide variety of lower animal species. Rapaport (1958) has extended, meaningfully, some of Hartmann's observations. Hartmann's (1950, 1956) concept that there is, already established at birth, a rudimentary ego, which tends to follow its own autonomous pattern of maturational differentiation—a process which is reversed in schizophrenia—is another concept which I have found helpful.

Thus, many of the bewildering manifestations of the paranoid patient's—or, for that matter, any other schizophrenic patient's—fragmentation can be seen to consist in such relatively obvious dedifferentiation phenomena as the loss of ego-boundaries, such that the outer world and the world within the self are mixed up, as in the phenomena of projection and introjection which I mentioned earlier; or the loss of distinction between present and past, such that persons in the present surroundings are misidentified as being persons from the past, and, contrariwise, vivid memories from the past are experienced as being perceptions of the here-and-now; or the loss of differentiation among thinking, feeling and acting, such that, for instance, the thought or feeling is reacted to as being tantamount to the deed.

But, as one studies such patients for years, one sees that the dedifferentiation is, in a subtler form, far more extensive than one had thought. One sees that the dedifferentiation of the thought processes, or to put it another way, the loss of the higher forms of ego-organization, is such that the patient has little or no realm of *fantasy* experienced as such; whenever he experiences a new combination of thoughts or mental images he immediately

assumes it to be, instead, a representation of outer reality. Further, he has little or no psychological realm of *memory*, experienced as such: people about him never *remind* him of people from the past whom he then *misses*; to him these either *are* those very people, or are those people in a disguised form, or—and this is true, perhaps, of the slightly healthier patient—they are ‘doing a take-off on’, or as one patient put it, ‘projecting’, people from the past.

Further, his inability to differentiate important from trivial, intendedly communicative from non-communicative, ingredients of the world around him may account for some of his well-known *suspicion*. He may be suspicious, that is, not only for the reason that he has been hurt too often before when he has placed his trust in someone, but also because his suspicion provides his only mode of processing, of sifting out, the data from a world which is as bewilderingly complex as the adult world is to a little child. Many times I have seen this or that paranoid patient start to look utterly confused by the many words and, simultaneously, manual and other gestures coming from me, until his attention crystallized, after a brief moment or two, upon some word or some gesture, whereupon it clearly appeared that he had found his suspicion once again confirmed, had found his delusional simplification of experience adequate to pigeon-hole this new incident, and had found relief from his momentary bewilderment in face of perceptual data which his capacity for abstract thought was insufficient to enable him to integrate on any but this primitive suspicious basis.

I have been particularly interested to discover how frequently the fragmented patient is involved in a kind of literal and somaticized experience of what would be, to a healthy person with mature ego-differentiation, a *figure of speech*—a metaphor, for example—confined to the levels of thought and emotion, with at most an echo of somatic representation (Searles, 1959a). For example, one patient reacted to a harsh comment from me without

any awareness that my comment had made her feel hurt and betrayed, but with the evident physical sensation, instead, of having been quite literally shot in the back. Upon seeing a pathetic elderly man in the nearby drug store, she remained quite unaware of the extent to which her heart had, figuratively speaking, gone out to him, as I could see in my immediately subsequent session with her; instead, she had an agonized literal experience that her heart had been torn out. Another patient, when shame and embarrassment started to emerge from repression, felt a literal, rather than a figurative, sensation of sinking through the floor. Other patients, when evidently involved in feelings of admiration or awe of me, have experienced this not as such, but as a perception of me as being gigantically tall; or, when grappling with feelings of disillusionment or contempt toward me, instead of experiencing the feeling as such, have perceived me as being a midget. They may perceive their fellow-patients, or themselves, as being not figuratively sheep-like or cow-like, for instance, but as being literally indistinguishable, perceptually, from sheep or cows, or even inanimate things. Even the earliest differentiation, in normal ego-development of infancy, that between animate and inanimate, may be lost (Searles, 1960).

Thus we see that the paranoid schizophrenic patient, when we begin working with him, is labouring under the threat not only of constellations of specific projections and introjections, but also of imminent disintegration and dedifferentiation of his whole personality-structure—such as becomes blatantly overt later on, when his delusional defences have been undermined midway along in his therapy. Our own psychodynamic understanding of this disintegration and dedifferentiation, as constituting very active (though unconscious) ego-defences of a primitive sort—whereby a part of the ego’s integrity is temporarily sacrificed in the interest of personality-survival (Searles, 1959a)—cannot serve directly to alleviate the threat under which the patient himself suffers.

Usually we can detect at least a few subtle indications, even at the beginning of our contact with a relatively rigidly organized paranoid individual, that he is struggling against such disorganization of his psychological processes. The following brief portion of a psychologist's lengthy report concerning a newly admitted woman with paranoid schizophrenia, a woman who needed hospitalization but was opposed to it and whose illness was not sufficiently overt as to make possible her commitment for prolonged treatment, is reminiscent to me of various patients I have seen. After detailing at great length the many evidences of adequate personality-functioning, the psychologist says:

I did get various definite evidences of a psychotic process going on in Mrs Bennett. In the first two hours I had with her she verbalized many rather bizarre somatic symptoms, such as a feeling that her hair had all been torn out during the stay at the previous hospital, although she said that she knew quite well that this had not actually occurred. Also, she described a feeling of 'being broken in two in the middle', indicating her abdomen. Likewise, she went into great and rather bizarre length in trying to describe some chronic lower back complaint.... During a subsequent hour with her, I found her to be describing her distress at being in the presence of one or another of the patients here who was knitting. She said, 'It makes me feel like wool—you know.' I could get no further elaboration about this from her.

Although this paper does not deal with therapeutic technique, I must touch upon that area in order to make an additional conceptual point concerning the paranoid patient's de-differentiation. The beginning practitioner of psychoanalysis or psychotherapy learns, in the early years of his experience with neurotic patients, how very much of what the patient is saying has reference, at some level of awareness or unawareness, to the immediate treatment-situation itself, although the patient may be quite resistive indeed to recognizing this transference-ingredient in what he is saying. After years of practice in detecting such immediate, though usually preconscious or un-

conscious, referential roots in what his patients say in his presence, the therapist or analyst becomes impressed, too, with the extent to which this phenomenon enters also into ordinary conversations between individuals in daily life. For instance, *A* is expressing to *B* some strongly felt attitude concerning an absent third person, *C*, quite unaware that simultaneously he is revealing, to a practised ear, that he holds this attitude, in some degree, toward *B* as well; and *B*, if he does not have a practised ear, is equally unaware of this quite direct communication from *A* to himself. But I, at least, have come to believe that such a direct referent is nearly always present in such situations.

Such ubiquity of this phenomenon would be in line with the work of Piaget (1930), whose voluminous and meticulously detailed researches concerning normal development indicate that the establishment of ego-boundaries, far from being completed in infancy or early childhood, is still considerably incomplete as late as twelve years of age, and never reaches full completion even in adult life. He speaks of one's perception of the outer world as being distorted, even in adult life, by at least some 'adherences'—that is, projections—of ingredients which belong, properly speaking, within the boundaries of the self. Thus we might think of this circumstance which I have been describing as one in which, even among so-called normal people, *A*'s perceptual differentiation between *B* and *C* is, at an unconscious level, not complete, such that the feelings which he is expressing about the absent person, *C*, may adhere to, or be directed toward, the person *B* who is actually in his presence.

In any case, whether or not this phenomenon occurs with such a high frequency as I myself believe it does, the paranoid schizophrenic patient may be thought of as being particularly acutely aware of this 'normal element of self-reference' in his contacts with people, when he is in the position of person *B*. Because his ego-boundaries are so grossly incomplete that the ingredients of the outer

world, including both persons *A* and *C*, are reacted to unconsciously or perhaps even consciously as mere extensions of himself, he is very prone to hearing, in *A*'s remarks about *C*, *only* that level of meaning which refers to himself, and to dismiss the significance of *A*'s consciously intended meaning.

At this juncture I wish to note how heavy a penalty one has to pay for the use of such psychotic defences against anxiety as massive projection and introjection, disintegration and dedifferentiation. The penalty, which has no counterpart in neurosis, consists in the experience of *weirdness* suffered, for instance, by the paranoid man who, in the struggle against repressed grief, feels that his streaming tear glands are controlled by some weirdly mysterious agency outside himself; or by the woman who, projecting her violently aggressive sexual lust, feels herself to be repeatedly raped by some eery and invisible outside agency. The self-concept is constricted by so harsh a superego that the warded-off desires, in order to emerge at all, have to assume so disguised a form that the patient lives, consequently, in a nightmarishly distorted world. Data from the only quantitatively more distorted world of hebephrenic patients provide vivid examples of what I am discussing here. One hebephrenic woman, unable as yet to conceptualize her subjective unfeelingness as such, recurrently saw an eerily unhuman 'plastic man' appear, terrifyingly, at her window; another, unaware of her murderous rage as such, experienced instead an hallucination of a line of exploding teeth marching unendingly up one wall of her room, across the ceiling, and down the other side; and a hebephrenic man, whose self-concept as a little girl was repressed and projected, saw in his clothes-closet an 8- or 10-year-old girl, swimming in purple liquid, and pleaded urgently for me to rescue her.

I have become interested in trying to discern in what form, if at all, the paranoid patient experiences any awareness of his own thought-disorder and, in general, of his ego-mechanisms. It required four years of therapy for one man, for example, to become able to say, 'See,

this is the way I think... ', and to proceed to lay out before me, for our mutual investigation, his distorted ways of thinking. Prior to such a development, I believe, the patient experiences his state of more or less severe dedifferentiation of ego-functioning not as any disorder within himself, but as, rather, an indistinguishable component of the poorly delineated 'them', the anthropomorphized persecutors in his external world. One sees comparable phenomena in normal development, in the little child who, only precariously established as yet in well-differentiated modes of thought, perception, and sensation, seemingly experiences his remnants of the earlier, undifferentiated level of ego-functioning not as a truly internal threat, but rather in the form of the vaguely outlined shapes which, he is convinced, lurk behind the closed doors and in the dark corners.

Tausk (1919), in his classic paper, 'On the origin of the "influencing machine" in schizophrenia', in which he introduced the concept of a loss of ego-boundaries, described the delusion of there being a fascinatingly complicated influencing machine, experienced commonly in that era by paranoid schizophrenic patients, as being in actuality a projection of the patient's own body, with the whole body being unconsciously fantasied as a genital. Since I have come to see how frequently schizophrenic patients experience abstract concepts in a concretized, and often anthropomorphized, form, I have come to believe that such phenomena as the influencing machine—which one of my patients experienced, for years, as a 'Watcher-Machine' protectively overseeing her daily living—represent, most significantly, the patient's own externalized, and to him fascinatingly complex, ego-functioning. Modell's (1958) paper concerning hallucinations as being related more closely to ego-functions than to superego-functions is relevant here, and much of my clinical experience is in line with his.

If there is any single most basic threat to the paranoid schizophrenic person, it is, I believe, the threat that he will cease to exist as a human

individual. This threat presents itself in various forms. There is the danger that his identity will be reduced to that of only *part* of a person—most often, a genital—rather than his being a whole person. There is the danger that his individuality may be submerged in symbiotic relatedness with the other person. There is the danger that his status in the world of his fellow human beings will be reduced to that of an animal, a dead person, or an inanimate object. And there is, finally, the danger that, in the eyes of human beings, he may cease totally to exist.

Interviews with the mothers of these people suggest some of the causative factors in the patient's unsureness that he can maintain any solid place in the emotional life of his fellow human beings. These mothers appear, so frequently, remarkably overcontrolled, placid—as the late Lewis Hill (1948) termed it, impervious. One mother states of the patient's father, in the most matter-of-fact tone it is possible to use: 'He died from ulcers of the stomach and cancer of the stomach and liver.' Another says, similarly dispassionately, of her son's infancy: 'There was quite an interval, at four months, when I thought he would starve to death, when he wouldn't either eat or take the bottle.'

The degree to which various of these parents disavow, whether unconsciously or even consciously, any blood-relationship with their child, is sometimes startling. One mother, for example, in giving me an account of the background of her schizophrenic daughter, now married, commented less with scorn than with emotional detachment: 'Mrs Matthews, from a young child, was always what we called the goody girl, the Pollyanna type: tractable, obedient, of a sweet disposition; and I thought that during her childhood and adolescence I had a good contact and understanding with Mrs Matthews.' For a short time, during our lengthy session, she referred to her daughter as Alice, 'to make it easier', but soon lapsed back into using the term 'Mrs Matthews' which seemed really more in accord with the way she regarded the young woman. Several times

I have been astonished to see, in the course of a patient's psychotherapy, that one or another of the parents felt that he or she had married far beneath his or her social station, to such a degree that the patient, in striving for acceptance by this particular parent, was met not only with rejection but with subtle reproach for trying to be a social climber.

Sometimes such attitudes are expressed quite openly. One mother, in telling me of her marriage, said: 'My father was violently opposed to it because he said it was worn out stock. He went to some pains to prove to me that it was stock that was on its last legs. He had done a lot of breeding of cattle', she explained—all in such a tone as to make clear that she had long ago come around to her father's way of thinking. She went on: 'There was so much T.B. and cancer in my husband's family that not only did three of my children have mental breaks, but one of his family had cancer and another one committed suicide. My side was stronger physically, stronger emotionally, stronger intellectually...; but his was an old New England family', in contrast to her own Southern background. She commented, at another point, that her husband always wanted a big boat, such as one his own father had once had. 'But', she went on, 'we couldn't afford it; we had six children instead. Perhaps it would have been better if, instead of having the children, we had gotten the boat.'

The devaluation, by various of these mothers or fathers, of their child's emotions and ideas is often readily detectable. One mother said that her son, from the time he was old enough to hold a pencil in his hand, until the age of about eight, used to draw for several hours a day. 'He drew all his ideas out in the form of cartoons, little series of pictures that followed a thing through... We got awfully amused at him, his odd little ideas', she commented, which reminded me of another paranoid patient's repeated references to his childhood as 'my little life'. Another mother said, of her son's graduation from a top-level preparatory school, that 'He wasn't anything', meaning

that he had won no class office nor athletic award. A father, with a similarly erasing kind of scorn, said shortly, of his schizophrenic son's academic achievements, 'He's a genius; but he's no good to me being a genius in that condition', referring to the son's incomprehensible 'refusal' to apply himself to any line of work.

The mother of a very strong, and at times dangerously combative, young schizophrenic man, when asked whether her son had ever struck her, calmly replied that several times he had grabbed her hair and pulled it, and that one time—a week previously, when she had been trying to persuade him to come to Chestnut Lodge, he had slapped her face. She went on, in a rather amused way, 'I knew he would', and added that at times he had pulled her hair 'not very hard, but like a child would pull somebody else's hair. It old him', she continued with a laugh, 'that I thought it was a great improvement—"At least you don't hurt anybody when you pull my hair."' A father, describing a drive he had taken with his paranoid daughter, while she had been home on a visit from the Lodge, mentioned that she had become enraged and hit his arm repeatedly, so hard that it was bruised for several days. I was astounded when he added: 'I wanted to concentrate on driving, so I acted as though nothing were happening.'

The effects of such parental responses, or lack of response, could be seen in one of my patients who, after much therapy, was able to confide to me, quite simply and resignedly, that 'nobody responds emotionally to me'. It required another patient several years of therapy to become free from her long-held, though previously unconscious, self-concept as a 'snow man in a glass'—one of those little snow men in a glass globe, with artificial snow—quite outside the realm of living human relatedness, and it was with the keenest pleasure that she finally became aware that, '*I'm alive*, Dr Searles'. Another patient felt, for years, that she was a robot, and at times other types of machines, before becoming convinced that she was a human being, capable of re-

sponding emotionally and of evoking emotional responses in other human beings. Earlier, she had phrased it that her family 'used me as thing for a their amusement'.

Another patient, after much therapy, said, weeping bitterly, 'I felt as though I didn't have anything that was mine, almost', and told of how, in the course of her childhood, her mother, without consulting her, had given her doll's house to a Society for Underprivileged Orphans, her doll's carriage to someone, her favourite sweater to a younger sister, and had had the girl's dog spayed; and an older sister, on going away to college, had taken as many as she desired of the patient's books, likewise without asking. A divorced woman, the mother of two small children, said of her mother that: 'If things aren't going along the way she wants them to, it is within her power to take away my financial support and take over my babies. She has threatened to cut off my financial support since I've been ill. She sold my house and she sold her house and bought a new house with room for herself, the maid, and the two babies, and', the patient ended with a hollow laugh, 'didn't leave any room for me.'

Always one can find evidence that one or both parents, during the patient's upbringing, have been so absorbed in *transference*-relatedness—traceable, that is, to unconscious elements in their own childhood relationships—transference-relatedness to various members of the marital family, including the patient, that the patient's existence in his own right receives little acknowledgement. For example, to one mother, the patient's long-deceased elder brother, an important transference-figure to the mother, was evidently still a much more alive and absorbing person to her than was her living schizophrenic son. In patients' marital family-relationships, also, one sees the same phenomenon: in a number of instances, I have found that a paranoid woman's husband is so absorbed in his relationship with their daughter, unconsciously a mother-figure to him, that the patient has come to have, for all practical purposes, no place left in his psycho-

logical life, or in the marital family-structure. Another patient said, of her childhood, that when her mother and her paternal grandmother, who lived in the home, were waging their chronic arguments, the 'tension was terrific', and 'I wasn't even given the acknowledgement of a piece of furniture in the room'.

Another woman, both of whose parents had been schizoid persons at best, and who felt convinced that she had had no single continuous home, or set of parents, said to a nurse: 'I've been in so many houses and been met with so many people behind newspapers. Either they didn't love each other or else I was to blame in some way for this...' This illustrates how vulnerable is the child, who finds so little assurance of his real ability to affect other people, to the development of a conviction that he possesses some magical, inhumanly destructive, power over them. Other causes for such a self-concept lie in his uncomprehended transference significance to—and thereby power over—his parents' feelings, and in his unconscious hostility.

Out of such multiple etiological factors, one patient felt herself to be less a human being than a 'force of evil'. Another patient confided, in a troubled tone, 'I work up the other person's destructiveness against life', and in describing her previously unsuccessful treatment, said despairingly, 'I was, and still am, impervious to any influence emanating from the psychoanalyst', and likened her own imperviousness to 'cancer'. At another point, she said, 'I felt that my little girl—as much as a child needs her mother—would be happier with her father; since I am so unhappy, couldn't help infecting her...'. One repeatedly finds, in the course of psychotherapy with these patients, their revealing a long-standing concern lest they convey their disease to other persons, as if it were caused by germs and communicable through physical contact.

Poignantly, in a number of instances this view of the self as being unfit for the world of human beings, by reason of some ill-understood destructive effect upon one's fellow-men, has seemed to represent an effort to account

for the physical isolation in which the little child lived, the deprivation in terms of physical and emotional contact with any parental figure. The quite evident anxious disorganization with which these mothers, and sometimes the fathers, have met the patient's strivings for intimacy with them, subsequent to his infancy, must be counted among the important factors in the child's developing conviction that his love has a destructive effect upon human beings.

Other etiological circumstances I can touch upon only briefly. There is the parent's inability to relate to the child as being a whole person; the little son may have psychological significance for his mother or father only as a penis; and the girl may be quite literally only a pair of pretty legs, or a pair of maternal breasts, to the father or mother. Further, there is the parent's inability to differentiate the child clearly from his siblings, or from the parent himself or herself. One of my patients, who had two sisters, two and four years younger than herself, in one session started to reminisce, 'When I was six four and two...', as if she felt herself to be literally one person with her sisters. Nearly a year later she was able to describe it that her mother 'never seemed to realize that we [girls] were different from one another'. One mother commented blandly, concerning her son: 'George objects violently if I address him in the tone I use in addressing either his father or his sister. He emphasizes [in the former instance], "I'm not Dad! I'm not married to you!"'. In the symbiotic relationship with the mother or father, the child is, of course, often under pressure to vicariously express the parent's unconscious feelings. One mother, who seemed largely unaware of her own very considerable paranoid hostility, in painting a particularly malevolent picture of one among the many physicians who had, she felt, mishandled her son, commented approvingly that 'Eddie said he felt like killing him and for two cents he would have'. Another mother, who gave a similarly paranoid account of her daughter's experiences with a long series of previous therapists, including a terse comment concerning one, 'The man was a beast

and did a bad job', and, concerning another, an even more terse, 'I'd like his head', seemed none the less to think of herself as a non-violent person, and, in tracing her daughter's background for me, said of a time when the young woman had been living with a lover: 'I lived in constant terror of what might happen that year; both are violent people, both are filled with hate, and anything could have happened.' It is somewhat remarkable to me that, despite such parental pressure, so many of these patients manage to avoid killing anyone.

I cannot elaborate, here, upon what might be thought of as the *internal* causative factors in the patient's fear that he may cease to exist as a living human individual. The resolution of these factors is invariably more difficult for him, and for the therapist, than is the clarification of the ways in which *other* persons have warped him. These internal factors, intimately related, of course, to the external ones, include: (a) his wide-scale repression of his emotions, which is one of the great causes for his feeling himself to be a dead person, or an inanimate thing; (b) his unconscious denial of his dependency-needs, such that he, regarding his therapist, for example, as being 'of no more importance to me than that spot on the wall there', as one of my patients phrased it, assumes, through a projection of such denial-of-dependency, that the other person considers *him* to be next to nothing; (c) the externalization of both sides of his internal conflicts, such that he feels himself to be a mere 'pawn', or 'rubber ball', buffeted about by the powerful beings upon whom these conflicts are externalized; (d) emotional withdrawal from human relatedness, as an expression of hostility, so habitually, and to such an extreme degree, that he feels himself to be, as one patient phrased it, a mere 'ghost'; and, lastly, (e) the clinging to the infantile view of other persons as being omnipotent and omniscient, which is a rather effective way for one to deal with one's feelings of guilty responsibility, but which leaves one with only the most tenuous room for existence as a functioning and significant human entity.

Any more comprehensive description of the etiology of paranoid schizophrenia would have to include two additional factors which I shall only enumerate here: first, the presence of deeply repressed love-feelings in the mother-child relationship—a factor which, as I have detailed elsewhere (1958), is predominantly responsible for the child's introjection of the mother's submerged personality-fragmentation, and for the mother's—since she is convinced, at a deep level, that her intimacy is destructive to the child—becoming, early in his infancy, psychologically so aloof from him; and, secondly, the failure of mother and child to resolve their symbiotic mode of relatedness, a mode of relatedness which is normally found only in infancy. Their symbiosis is maintained into the patient's chronological adulthood, and those feelings, or other psychological contents, in either party which threaten the symbiosis are projected on to the world around the two. Not only such feelings as hatred and lust are projected on to the outer world, which therefore appears correspondingly threatening to the child; much of his own ego-capacities, also, being incompatible with the symbiosis with his mother, are projected on to various other figures, who are seen for a time as being larger than life, but always with eventual disillusionment. We might think of it that both the child and his mother have been unable to successfully traverse the ambivalent phase of his infancy—or, more accurately, the ambivalent phase of the mother-infant relationship, since this is a phase which, in normal development, is one of ambivalence not only for the child but also for the mother. In order to achieve true object-relatedness, as contrasted to symbiosis, this mutual ambivalence must be faced, accepted, and integrated into each person's concept of himself and of the other one.

The threat which his genital lust poses to the paranoid schizophrenic individual can be understood most meaningfully, I believe, in connexion with the structural phenomena of symbiosis, non-differentiation, and dedifferentiation which I have already touched upon. His sexual identity is poorly differentiated,

and although other areas of his personality are equally poorly demarcated, the culture is particularly punitive in regard to incomplete sexual differentiation. Moreover, his own unresolved infantile omnipotence, a facet of the unresolved mother-infant symbiosis, is directly threatened by the necessity for him to accept a single sexual identity, as either male or female, and relinquish the complementary one; he cannot be wholly a man—or she, wholly a woman—without relinquishing that tenaciously held fantasied omnipotence. Further, the advent of genital lust at a time when his object-relations are at a level predominantly of symbiosis with the mother—herself poorly differentiated sexually, with a strongly, though unconsciously, phallic body-image—means that the sexual drive will be directed either toward the mother, or toward mother-surrogates, with connotations of both incest and homosexuality for the child, whether boy or girl. Another important ingredient, in the threat which lust poses for these young people, is traceable to their greatly thwarted identificatory needs; the young woman's need to identify with an adequate mother-figure is experienced as an utterly unacceptable 'Lesbian tendency', and the young man's need to identify with an adequate father-figure is experienced as an equally shameful 'homosexual tendency'.

The lust, although genital in expression, actually operates, as regards its psychological significance in object-relations, upon at best an oral level—that is, the first developmental stage beyond full symbiosis—with the result that sexual intercourse is reacted to as posing the threat that one will eat, or be eaten by, the sexual partner. Most often, I think, the cannibalistic feelings which in the healthy person are relatively readily admissible to awareness, as a natural concomitant of oral needs dating back to earliest infancy, in the paranoid individual are, by contrast, deeply repressed and projected on to the other person, such that the fear is of being devoured by the other in the sexual act. With each of the paranoid schizophrenic patients who have progressed far

toward health in my therapeutic experience, it has required years of therapy for them to become aware of cannibalistic desires. Prior to such a development, their view of sexual intercourse is well epitomized by this poem, composed by an intellectually brilliant and witty, but deeply paranoid, young man. This is a parody upon Edgar Allan Poe's 'Annabel Lee', and is entitled,

Miss Cannibalee

It was many and many a day ago,
 In a city you all can see,
 That a maiden lived whom you might know
 By the name of Cannibalee;
 And this maiden she lived with no other thought
 Than a passionate fondness for me.

I was a lad and she was a lass;
 I hoped that her tastes were free. [love,
 But she loved with a love that was more than
 My yearning Cannibalee;
 With a love that could take me roast, or fried
 Or raw, as the case might be.

And that is the reason that long ago,
 In a city you all can see,
 I had to turn the tables and eat
 My ardent Cannibalee—
 Not really because I was fond of her,
 But to check her fondness for me.

But the stars never rise but I think of the size
 Of my hot-potted Cannibalee.
 And the moon never stares but it brings me
 Night mares
 Of my spare-rib Cannibalee;
 And all the night tide she is restless inside
 Is my still indigestible dinner belle bride,
 In her pallid tomb, all rent free,
 In her carnivorous sepulchre,—me.

Although such repressed emotions as hostility and lust may readily be seen, early in our work with any one of these patients, to account for some of his paranoid anxiety, as we go on with him we find that each one of the whole range of human emotions has been, in him, long repressed as constituting an equally important source of this anxiety. It may require many months for us to see how filled he is, too, with loneliness, unfulfilled dependency,

and feelings of abandonment; with fear and guilt, helplessness and despair; with disillusionment and grief; with heretofore-stifled compassion and boundless love. These feelings are not easy to hear expressed, as, for instance, when a woman who, at the beginning of her therapy, had been encased for years in flintlike paranoid defences, becomes able to express her despair by saying that, 'If I had something to get well for, it would make a difference'; her grief, by saying, 'the reason I'm afraid to be close to people is because I feel so much like crying'; her loneliness, by expressing a wish that she could turn a bug into a person, so then she'd have a friend; and her helplessness in face of her ambivalence by saying, of her efforts to communicate with other persons,

'I feel just like a little child, at the edge of the Atlantic or Pacific Ocean, trying to build a castle—right *next* to the water. Something just starts to be grasped [by the other person], and then bang! it's gone—another wave.' And it is not entirely easy, either, to find oneself, in course of time, so important to, and adored by, the patient that he clearly yearns to be the ring on one's finger, sees one's face everywhere in people about him throughout the day, and finds that the days on which he has no therapeutic hour do not exist, in retrospect, for him, like so much time out of his life. But when he has become able to express any of these feelings, we can know that he is well in process of leaving his paranoid fortress, and joining the mainstream of his fellow human beings.

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Personal relationships in clinical psychology

By RALPH HETHERINGTON*

Clinical psychologists tend to fall into two groups, distinguished by their approach to their work. One group has emphasized the need for exact psychometric methods, and has consequently chosen techniques thought to be objective. Such techniques seek to minimize reciprocal effects of the personalities of the psychologist and patient. Indeed the rationales of such methods tacitly assume that such factors can be ignored.

The other group has emphasized the need for establishing a personal relationship between the psychologist and patient, as being the only way of obtaining a real understanding of the problems involved. Possible causes of this divergence of opinion will be considered later.

Much has been written in support of the former point of view, less in support of the latter. This paper is an attempt to redress the balance.

The need for good personal relationships in creating and maintaining mental health has always been recognized. When a person becomes solitary and withdrawn and avoids his fellows, we suspect mental illness. The work of Bowlby (1951), Spitz (1949) and others recently summarized by the Clarkes (1960), has shown the need for good personal relationships in early childhood; Sargant's book *Battle for the Mind* (1957) has given evidence that normal stable individuals rapidly deteriorate, becoming temporarily neurotic or even psychotic, when denied normal emotional interchanges with other people. Solitary confinement in prison is one of the most dreaded of punishments, and is an important ingredient

of the brainwashing process. Nursing lunatics together in wards, was discovered to be greatly superior to confining them alone in cells. Miraculous changes can be produced in emotionally deprived children by giving them unstinted affection. Some schizophrenics can be made symptom-free if given close personal attention by one person, but often relapse when the relationship is terminated.

The most useful technique employed by the clinical psychologist in establishing a personal relationship with his patient is, perhaps, the psychological interview and the various test procedures stemming from it, by means of which he is able to gain some knowledge of his patient's interior experiences and exterior behaviour. The problems involved in studying exterior behaviour are by now fairly well known, and include the psychology of perception, testimony, report, interpretation and so on. But the problems involved in studying other people's interior experiences have been less adequately studied. Two theories have been advanced to account for the ways in which we become aware of the experiences of others. The first is the theory of reasoning by analogy: we can become aware of our own behaviour and the interior experiences which accompany it. We can then reason by analogy that when other people behave in similar ways they must be having experiences similar to ours. For example, when we laugh we often feel happy. From this observation we argue that when other people laugh they too are probably feeling happy. The second theory is the theory of empathy which states that we are able by an effort of imagination to feel with other people sympathetically, and come to experience a sort of copy of what they are feeling. For example we meet a mother who has lost her child and then imagine what she must be feeling like in

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such a situation. By so doing an emotion arises in us which we suppose is similar to hers. Now both of these theories require that a knowledge of oneself precedes a knowledge of other people. But it is clear that children and, indeed, animals, behave as if they were aware of other people's interior experiences, although neither children nor animals are usually considered to be capable of self-awareness, nor can they reason by analogy. Other people's psychic experiences would appear in some way to be directly reacted to, and thus presumably directly perceived. Koffka (1928) examines this question and asks: 'Is it not possible that phenomena such as "friendliness" and "unfriendliness" are very primitive—even more so than the visual impression of a "blue spot"?' Thouless (1951) uses the term 'social induction' to cover suggestion, sympathy and imitation, speaking about the phenomena of 'mutually induced' opinions, emotions and courses of action, in groups of people or animals. He speaks rather vaguely of 'distress of one member leading to sympathetic pain and relief of the distress on the part of others, and the anger of one member producing anger in others'.

Scheler (1954), in his book, *The Nature of Sympathy*, discusses this issue at somewhat greater length. He asserts, with Koffka, that we have a direct awareness of the psychic life of our fellow humans. We are, he suggests, initially aware of psychic phenomena—friendliness, hostility, happiness, misery and so forth—and only later do we differentiate between those phenomena which are ours and those which belong to others. We first become aware of 'friendliness' and only then do we begin to ask: 'Is this his friendliness to me, or mine to him?' In fact Freud, in his theory of projection, has cast serious doubt about the source of friendly feelings perceived in other people. They may after all only be projections of our own attitude. Stark, in his introduction to Scheler's book (1954), states the latter's position thus:

When we come to integrate our own self—to cut it out of the texture, as it were, in which it had

formed one indistinguishable strand alongside many others—we continue to see it against the background of a surviving, although progressively receding, common consciousness which contains, in principle, the experience of others as well as the experience of the self. It is this fundamental fact which, according to Scheler, explains our knowledge—our *direct* knowledge—of the psychic life of our fellow-humans. Far from living in them, as the theories based on analogy and empathy would suggest, *they* live in *us* because ego and non-ego have both emerged out of a common stream of life-experience and are thus... twin-born and not antithetic.

The only contemporary psychologist to come anywhere near this position seems to be Raven (1952). In his book, *Human Nature*, he describes what he calls 'passive sympathy':

Under some circumstances people appear to be immediately aware of the affections, experiences, thoughts, hopes and intentions of another person. For this reason people will sometimes speak of telepathy between them, or of some kind of religious experience, as the result of which the experience they share seems in some way more than the experience of either person considered separately.

Ainslie Meares, in a recent article in the *Lancet* (1960), has examined the question of communication with the patient, and has emphasized the large number of channels which are in fact employed. In addition to 'literal verbal communication', he cites what he calls 'extra verbal communication', consisting of vocal stress, tone of voice and innuendos. He suggests that this type of communication is highly sophisticated and of recent appearance in the history of man's development. This type of communication is lost, he says, by many schizophrenics. There is also 'unverbalized phonations' such as 'ums' and 'ahs'; facial expression, posture and gesture, and behaviour in more general terms. These, presumably, are the more primitive types of communication referred to by Koffka (1928). Meares points out that the content of communication can be both conscious and unconscious, consisting of affect

and attitude as well as opinion and idea. To quote his own words:

Our therapeutic communications with the patient include the establishment of rapport. This is the doctor-patient relationship which allows of effective psychotherapy.... This is an emotional relationship.... Some ideas can be effectively communicated only by non-verbal means. To understand his patients the physician should be competent in the language of non-verbal communication.

If, then, the interview is central to the work of the clinical psychologist, we are led immediately to some important implications. The first of these concerns the selection of psychologists for clinical work. Interviewing involves the use of personality, employing the term in its biosocial sense. The very interviewing and testing of a person will modify him, and the personality of the examiner will have some effect on the data he obtains. An obvious example is seen in a test like the Rorschach. A shy young male subject is less likely to admit seeing sexual anatomy in the blots, when tested by a young female psychologist, than he is when tested by a middle-aged male psychologist. A young male psychopath might tend to give more of such responses if he wished to shock the girl, but would not bother with the man. In the same way the personality of the patient will modify the psychologist and alter his attitude to the patient. In his attempts to get more out of the patient and to win his co-operation, the psychologist will display those facets of his personality he thinks will best serve the situation. If one is interviewing an elderly army officer one calls him: 'Sir', if it is a young boy one uses his Christian name. Some elderly women like to be called 'Ma', others expect a more formal approach. One is hearty, subdued, sympathetic or off-hand as the occasion demands. But this is never arrived at by detached, cool appraisal, as the result of the logical weighing of alternatives. One *feels* one's way into a situation and acts intuitively. Only a theory of empathy such as Scheler's makes any serious attempt to study

situations such as these. It follows then that the personality of the psychologist becomes an important tool in his kit-bag, perhaps the most important, since it is the one he uses all the time. A major factor in the selection or rejection of a candidate for clinical training will therefore be his personality: his ability to achieve rapport quickly and easily, to get the feel of a situation, and to induce all sorts of people to feel relaxed and at ease in a friendly, sympathetic atmosphere. Important also, is his ability to accept all kinds of people uncritically, and genuinely to enjoy their company. This sort of psychologist is rather different from at least one prevailing stereotype. Eysenck (1957), for example, describes his ideal psychologist as follows:

We have in mind someone with a good background in the exact sciences and mathematics, with a solid foundation in learning theory and perception, and experience in the use of the experimental method and of statistics in a clinical setting.

A second implication of this thesis concerns the training of psychologists. The basic training will be in the handling of the patient and the interview situation. Such considerations as the use of white coats, the placing of desks and chairs, and the lighting of the room all become important. Do you put the patient in the light or in the shadow? Do you face him squarely or sit sideways to him? Or do you, like the analyst, retreat out of sight altogether? Do you have a desk between you and the patient? If so, does he sit up at the desk with you, or does he look up to you from a low armchair? Or again, like the analyst, do you lie the patient down? Some psychiatrists like to conduct their first interview with a patient, while they are doing a physical examination, which will of course establish relative roles unequivocally. Do you go and fetch the patient from the ward or out-patient hall yourself, or do you ring a bell and have him brought to you by a nurse? When he comes in do you continue to mark the test protocols of the previous patient, waving the newcomer to a chair with a grunt; or do you get up and give

him some sort of a welcome? All such questions have to be considered and worked out to the psychologist's own satisfaction during his training.

Once the interview has been mastered it may not be necessary to teach the student to use a vast battery of tests, or to become unduly worried if he has not had the opportunity to use some techniques more than two or three times. It might be better rather to encourage him to develop those techniques he finds most useful and suitable to his own individual way of working—providing he has had an opportunity of giving most of the available tests a fair trial.

Since a good deal has been said about the importance of the psychological interview, it would be as well to give a little more information about the rationale and use of the writer's 'Standard Psychological Interview'. This interview is given whenever there is the least doubt as to the area of the problem. Its purpose is twofold: to observe the patient's appearance and behaviour in a standard situation and to obtain an account of his own opinions about himself and his problems. Needless to say, since each worker has a unique personality which affects his own standard interview, each builds up his own norms. The method is to hold a conversation with the patient which is guided over a standard series of topics. If the patient introduces one of these topics spontaneously, but out of order, it is dealt with at once and not postponed. Otherwise the topics are introduced in a standard order designed to deal with those which are less emotionally toned first. Notes are taken of what the patient says, as far as possible, verbatim. If facilities for tape-recording exist, and if the patient agrees, the interview can be recorded. Notes are also made of the chief stimulus or pursuit questions put by the psychologist. As convenient, brief notes are also made of the patient's appearance and behaviour. The topics, in order, are as follows: interests, likes and dislikes, attitude to job; relations to others (including a fairly detailed inquiry into family relationships); attitude to past and future;

attitude to illness or current problems. In this technique the patient is encouraged to do most of the talking, and the situation is in no sense a questionnaire, although care is taken to see that all topics are covered. Psychiatrists sometimes ask how this technique differs from a psychiatric interview. The difference lies in the fact that the psychiatrist is after the 'facts' and will continue to cross-examine the patient until he obtains some sort of consistent picture. The standard psychological interview is more concerned to note what the patient is willing to tell that particular psychologist in a relatively standard situation. In this case his responses to the situation are more important than the facts. At a later stage it is often informative to compare what the patient has told the psychiatrist with what he has told the psychologist.

A third implication concerns the choice of tests and techniques of inquiry. No technique would be employed that impaired the relationship which has been established in the initial interview. Thus any technique which required the patient to work through long, tedious, and apparently meaningless tasks would be avoided. Many questionnaires come under this category. An example might be the M.M.P.I. All tests should be seen by the patient to be relevant to his needs, or if not, he should have sufficient confidence in the psychologist to accept the latter's judgement as to its relevance. It would seem inadvisable to tell a patient a falsehood about a test. For example some workers represent the T.A.T. as a test of imagination, which is very much less than a half-truth. Equally it would be dangerous to tape-record an interview without the patient's knowing you were doing so; or secretly to employ a one-way screen. All such procedures would impair the mutual trust and confidence so vital to real understanding.

By paying attention to the relationship between the psychologist and patient, conditions are established early which make psychotherapy a natural development. In 1947 the Committee on Training in Clinical Psychology of the American Psychiatric Association published a memorandum (1947) which made it

clear they considered 'therapeutic contact with patients' an essential part of the training experience of the clinical psychologist. This Committee proceeded to be more specific as to the type of therapeutic experience they considered necessary. To quote from their report:

psychologists in our opinion must come around to the acceptance of some kind of intensive self-evaluation as an essential part of the training of the clinical psychologist. We are not prepared to recommend any special form of such procedures although some of us believe that whenever possible this should take the form of a psychoanalysis.

As might be expected this produced a sharp reaction in the shape of an article by Professor Eysenck (1949), in which he made the categorical statement that:

it is our belief that training in therapy is not, and should not, be an essential part of the clinical psychologist's training, that clinical psychology demands competence in the fields of diagnosis and/or research but that therapy is something essentially alien to clinical psychology.

Since the development of behaviour therapy based on learning theory, Eysenck has somewhat modified his view, and has accepted this form of treatment as a proper activity for clinical psychologists, whom he sees in a role comparable to the physiologist, capable of initiating and carrying out therapeutic procedures. Thus having originally declared that therapy is 'essentially alien to clinical psychology', he now suggests that psychologists should become completely responsible for certain types of treatment. However, it is only fair to point out that Eysenck's chief objection to therapy was the suggestion that psychologists might have to undergo an analysis before starting work (1950). Another reason which he adduced later (1952) was that there was no proof that psychotherapy did any good anyway and, in the absence of any evidence to suggest it did, psychologists were best advised to have nothing to do with it. However, this argument could equally well be applied to behaviour therapy.

While it would be most undesirable for a training analysis to be a *sine qua non* to a psychologist's training, all psychotherapy necessarily involves 'some kind of intensive self-evaluation' on the part of the psychologist. The American Group for the Advancement of Psychiatry in their report no. 10 published in 1949 examines the conditions and safeguards under which such work could best be done by a psychologist. To quote from the report:

The Committee is strongly opposed to the independent private practice of psychotherapy by clinical psychologists. The Committee also feels that psychotherapy done by clinical psychologists should be carried out in a setting where adequate psychiatric safeguards are provided. . . . This Committee does not feel that the association of clinical psychologists as psychotherapists with general practitioners, or medical specialists other than psychiatrists is ordinarily a wise arrangement.

Although one would agree with these two statements it should be pointed out that the psychologist can quite properly work with other medical men or even on his own, in situations which do not involve psychotherapy. For example he could provide psychological data to a pediatrician or to a G.P. if the need arose. He could, and often does, provide psychological data to meet educational and industrial needs.

We can now consider possible causes of the divergence of view between clinical psychologists, referred to at the beginning of this paper. Sir Thomas Lewis (1930), as long ago as 1930, discussed the difference between the approach of the research worker and the clinician. He suggested that the two approaches were antithetical. The clinical approach, he says, 'deals with the individual' who is 'a human being in trouble'. To the research worker, who is 'collective in his outlook', 'the patient is one who exhibits phenomena of disease, phenomena to be compared and correlated with those displayed by other subjects'. He likens the clinician to the craftsman who 'dwells on what he knows, and delights to use and to display his knowledge'. The mind of the research worker 'dwells in the

main on the unknown and puzzling, and his eagerness is often towards displaying doubts and difficulties'. 'The divergencies between practical and scientific medicine are perhaps as profound as... those exhibited in the past between orthodox religion and science.' 'Experimental research upon disease may very readily come into conflict with full solicitude for the sick.'

These statements are of course very challenging to the clinical psychologist, and there is no doubt that many feel in something of a dilemma here. This is reflected in the tendency for clinical psychologists to regard themselves either as scientific medical auxiliaries or as members of the medical team in the ward or clinic. Sir Thomas Lewis asserts then, that clinical work and research are totally opposed, the former being more of an art than a science. Psychologists might therefore feel they should decide whether they will be research workers or clinicians. Since they have been trained as scientists, many declare that they should be research workers. This argument seems somewhat oversimplified. While Sir Thomas Lewis is undoubtedly right in suggesting there is a dichotomy between the research and clinical attitudes there is no cause to suppose that clinical work is therefore unscientific. Graham White (1956) and Shapiro (1954) have both drawn attention to the fact that there need be no essential difference between experimental and clinical psychology. There is no reason why clinicians should not attempt to be experimental in their approach to medical problems, using techniques which have proved successful in the past in giving information leading to reliable diagnosis, or employing methods which have led to cures. As Shapiro has pointed out, the diagnostician's method should consist of advancing hypotheses as to what is wrong with the patient, and then devising experiments to reject or confirm them. While clinical and research work are both experimental and scientific, the difference between them lies in their goals rather than in their methods of achieving them. Research seeks knowledge. Clinical work seeks cured patients.

We can now examine the effect of these two points of view on the way the psychologist works. Diagnostic investigation of the single patient is something which all psychologists are expected to do, however research minded they may be. In the choice of tests and techniques for this purpose, all psychologists have to be critical and discerning, only using tests with a sound scientific basis. In this there is little divergence of view between the psychologist with research interests as opposed to the one with clinical interests. It is, however, in the way he organizes his work and in his relations with his colleagues that the two begin to differ.

For the psychologist who is primarily interested in research, his diagnostic findings will be regarded as a source of research material. He will arrange matters so that he works from a department quite separate from the ward and clinic. He will visit patients when necessary for the purpose of testing, or patients will be asked to visit him in his own department. His contact with the ward or clinic will be in the role of the visiting expert with a specific problem to tackle or question to answer. He will expect to provide information but not to have any direct effect on the patient. His role will be very similar to that of the radiographer, biochemist or electroencephalogram recordist. Quite often his department will be referred to as the 'psychological laboratory'. He will think of himself as a 'Scientific Medical Auxiliary'.

The psychologist who is primarily interested in clinical work and treatment will often be able to use his diagnostic tests as a starting-point for therapy. He will choose those tests and techniques which help to develop his personal relationship with his patient, and will avoid those, however scientifically respectable, which tend to put his patient at a distance from him. He will have his own room in the ward or clinic like other members of the therapeutic team. The patient hears him talked about by other patients, meets him in the corridors and so on. It is generally recognized that many patients go to see the psychologist at some

time or other. He is always about the place, and is not just 'the chap over from the lab.'. The advantages of this arrangement in the easier handling of the interview are clear.

Some writers have criticized this way of working by saying that when he works this way, the psychologist is not being true to his scientific training, and that he merely works as an untrained, assistant psychiatrist. Some essential differences between the training of the psychologist on the one hand and the psychiatrist on the other must therefore be pointed out. The psychologist comes to the therapeutic team with an academic knowledge of normal psychology, while the psychiatrist begins with a training in general medicine. The psychiatrist, with his clinical training, is concerned to elicit symptoms from the patient which may lead to a diagnosis and thus to treatment. The psychologist, on the other hand, is more inclined to describe the patient in terms of personality traits in which pathological symptoms are seen as deviations from the normal. The psychiatrist's training has given him a knowledge of the abnormal, the deviant and the pathological, whereas the psychologist has a knowledge of the normal range of human experience and behaviour against which pathological deviations are assessed. The two disciplines also lead to distinctive roles in the team. Whereas the doctor is inevitably placed in a position of authority, the psychologist is not. He is not required, nor is it ever necessary for him to give orders to the patient or to anyone

else. His advice may often be sought, but he never assumes authority. In this sense he never has 'patients of his own'. This arrangement often provides opportunities for the patient to work out his problems when he needs some non-authoritarian figure to consult. When this point was made in an article written for the *B.M.J.* some years ago (1956) the writer was severely taken to task by a correspondent for trying to evade responsibility for his work. However, to be non-authoritarian is not the same as being irresponsible. The psychologist is of course required to take full responsibility for all that he does: to take the blame for his mistakes, and he would hope, the credit for his successes.

The work a psychologist does in the ward or clinic, and the role he plays, will depend on himself, his relations with the nursing and medical staff, the relative experience of the various members of the team and so forth. The group dynamics of the team will decide what he gets to do. Naturally if intense therapeutic situations are to be employed, members of the team have to know each other very well indeed. The leader of the team is always the psychiatrist who has to exercise the final authority. One may feel glad that this is so. It is not an enviable burden. A satisfactory team relationship of this sort, involving psychiatrist, psychologist, nurses and social workers, should obviate most of the problems of status, recognition and role, so anxiously discussed by Eysenck (1957) and by Payne (1953).

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A method of measuring psychological changes specific to the individual psychiatric patient*

By M. B. SHAPIRO†

The experimental clinical psychologist at present lacks techniques which will enable him: (i) to measure changes in the specific psychological symptoms, as reported by a given psychiatric patient; and (ii) to do so in a manner which makes possible comparisons between different patients and between different aspects of a given patient's illness. The purpose of this paper is to describe a technique which meets these requirements. For want of a better name the technique is called the 'personal questionnaire'. Only psychological symptoms which are unpleasant to the patient are dealt with by the particular form of the technique reported here.

Unlike questionnaires in common use, a different personal questionnaire is constructed for each patient. Construction takes about five hours, and each administration and scoring about thirty minutes.

Form of the questionnaire

The form of the questionnaire is that of pair comparisons, which was chosen mainly for two reasons. The first is that the experimental

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A manual of detailed instructions is being prepared and will be made available to psychologists wishing to do research with the personal questionnaire. The charge has not yet been decided.

literature indicates that the minimum number of two choices per item maximizes the reliability of a test as a whole (Fiske, 1957). Pair comparisons have the advantage of making possible a large number of discriminations along a chosen continuum, while at the same time only requiring discrimination between two items at a time. The second reason was the need to find a method of testing which minimized the influence of irrelevant response sets (Cronbach, 1950). An irrelevant response set is a tendency of a subject to respond systematically to those aspects of a test which have nothing to do with the test designer's intentions. For example, it is now well established that, in responses to questionnaires which present the subject with choices of 'Yes', '?', or 'No' in answer to each item, there will be a tendency to select one of these three responses regardless of the content of the question. This is only one of a number of different kinds of irrelevant response sets which have been demonstrated experimentally. Cronbach has reported that some form of forced choice minimizes the influence of irrelevant response sets. Pair comparisons seemed to provide a method of forced choice, while at the same time making possible a systematic form of calibration.

Method of construction

The first stage in the construction of the personal questionnaire consists of conducting a standardized interview with the patient. The aim of the interview is to obtain a list of his symptoms described in his own words. In the second stage the psychologist discusses the list with the patient's psychiatrist, and they then interview the patient together to clear up any

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differences concerning the clinical relevance or content of any of the statements. This is done in order to ensure the clinical relevance of the statements. The statements drafted at this point are called the 'illness' statements.

The third stage is the construction of a trial questionnaire. For each statement describing a symptom, two additional statements are formulated. The first, called the 'improvement' statement, is designed to indicate that the patient is improving, but still having a sufficiently unpleasant experience to require medical attention. The second, called the 'recovery' statement, is intended to indicate that the symptom is no longer unpleasant enough to require medical attention. A number of arbitrary rules of expression have been developed to speed up the drafting. When drafting a statement, the psychologist aims at describing a definite degree of unpleasantness of experience, defined in the terms of the Singer-Young Affect Rating Scale (1941), which was standardized in accordance with the method of equal appearing intervals, devised by Thurstone and Chave, on a group of 125 American students. This means that these subjects have shown maximum agreement concerning the degree of unpleasantness which each term implies. At the same time, the terms are definitely separated from each other, at approximately equal intervals, along a supposed subjective dimension of pleasantness-unpleasantness. The contents of the 'illness' statements have very unpleasant implications; those of the 'improvement' statements, moderately or slightly unpleasant, and those of 'recovery' statements, slightly or moderately pleasant implications.

In the fourth stage the patient's understanding and correct rating of the statements for their implications of unpleasantness, are ensured by a special scaling experiment. The patient is asked to rate in turn each statement, typed on a 5 in. $\times$ 3 in. index card, for the unpleasantness of the state of mind, implied by it, in terms of the Singer-Young Scale. Any failure by the patient to agree with the psychologist's intended rating is immediately discussed

with the patient, and an agreed and appropriately rated statement formulated.

The test in its final form consists of a set of 3 in. $\times$ 5 in. index cards, upon each of which a pair of statements has been typed, one above the other, in balanced order to remove the effects of position set. Only statements concerned with a given symptom are paired. There are thus three cards related to each symptom. The test procedure consists of showing the patient the cards, one at a time. He is asked to say whether the top or the bottom statement is nearer to his present state.

Reliability

A test of reliability, derived from Kendall (1948) is based upon the fact that, if the patient's responses are wholly random, then his response patterns will be equally divided among the eight response patterns indicated in Table 1. (Note that in Table 1 the sign $\rightarrow$ denotes 'preferred to', and the sign $\leftarrow$ the opposite. A denotes the 'recovery', B, the 'improvement', and C, the 'illness' statements.) Appropriate tests of significance, such as χ^2 , can indicate the degree of reliability of the data.

Table 1. *Response patterns*

No.			
I	A $\rightarrow$ B	A $\rightarrow$ C	B $\rightarrow$ C
II	A $\leftarrow$ B	A $\rightarrow$ C	B $\rightarrow$ C
III	A $\leftarrow$ B	A $\leftarrow$ C	B $\rightarrow$ C
IV	A $\leftarrow$ B	A $\leftarrow$ C	B $\leftarrow$ C
V	A $\rightarrow$ B	A $\leftarrow$ C	B $\rightarrow$ C
VI	A $\leftarrow$ B	A $\rightarrow$ C	B $\leftarrow$ C
VII	A $\rightarrow$ B	A $\rightarrow$ C	B $\leftarrow$ C
VIII	A $\leftarrow$ B	A $\leftarrow$ C	B $\rightarrow$ C

Scoring

The scoring system is based on the assumption that when, during an actual test, a patient chooses a statement, that statement has for him not very different implications of unpleasantness as it did when he made his first judgements during the construction of the test. This assumption has to be checked experimentally, and therefore it is necessary to repeat

the scaling experiment at least once. It is preferable to do this at the end of the experiment. A four-point scoring system can be used. Response Patterns Nos. I, II, III and IV can each be regarded as indicating a definite part of a continuum of increasing unpleasantness of experience, e.g. to reproduce Response Pattern No. I for a given symptom, the patient would have preferred the 'recovery' statements to the 'illness' and the 'improvement' statements, and the 'improvement' to the 'illness' statement. The four response patterns can be arbitrarily awarded scores such as 1, 2, 3 and 4, in accordance with their numerical order above. Response Patterns Nos. V, VI, VII and VIII are inconsistent with our dimension of illness. If they occur very rarely they would presumably be the outcome of slips of the tongue or hand by either the patient or psychologist. In that case, arbitrary scores could be assigned, for purposes of statistical analysis, to inconsistent response patterns; say a score of 1 to Response Pattern No. VII, 4 to No. VIII, and 2.5 to Nos. V and VI.

An example

The results obtained from a 28-year-old unmarried woman are now presented. She had a depressive illness of three years' duration and, an equivalent I.Q. of 83 on the Mill Hill Vo-

cabulary Test. Measurements were taken nine times at roughly weekly intervals. The 'illness' statements are given in Table 2. Examples of 'improvement' statement were 'I have a little energy' for the first 'Depression' statement in Table 2, and 'I feel it is possible I look peculiar' for the first 'Delusion of Reference' statement. Examples of 'recovery' statements for the same two 'illness' statements were: 'On the whole I have some energy', and 'On the whole I do not feel I look peculiar'. Out of the total of 180 response patterns only three were inconsistent, being 'circular'. The statements were classified as indicated in Table 2, in accordance with their apparent content.

Examination of the graph which plots changes in the average score for each class of symptom, shows that there are large fluctuations from occasion to occasion in the degree of illness, an analysis of variance producing an F of 15.96 ($P < 0.001$).

Two kinds of statistical comparison can be made between different classes of statements by means of analysis of variance. In the first place, the over-all difference between the six classes of statements can be compared. This comparison yields an F ratio of 2.170 which, does not reach the 0.05 level, for which an F of 2.96 would be necessary. The second way in which the classes can be compared is in the

Table 2. '*Illness*' statements

Thinking difficulties	Depression
My mind is very unclear	I have not got any energy
I can't put my mind to anything	I cannot go out and enjoy myself
	I feel very depressed
Hostility	I feel very much like crying
I feel very much like hitting people	I have a miserable feeling in my eyes
I feel very much like throwing things	I feel that life is not worth living
I feel very much like screaming	
	Somatic
Hypochondriacal delusions	I am unable to sleep at nights
I feel certain that I am going mad	My appetite is very poor.
I feel certain that there is something eating away my brain	I have a terrible pain in my head
Delusions of reference	I suffer very badly from constipation
I feel certain that I look peculiar	
I feel certain that people laugh at me	
I cannot bear crowds	

difference between their mode of fluctuation from occasion to occasion. According to the graph, there appear to be quite considerable differences in manner of fluctuation. For example, the hypochondriacal delusions rapidly recovered, whereas the somatic complaints, while fluctuating considerably during the illness, were still quite severe at the end of the period of measurement. The over-all significance of differences in mode of fluctuation is

investigation of the single case, i.e. for 'individual-centred' research. For example, Shapiro & Ravenette (1959) subjected a patient with paranoid beliefs to two kinds of discussion: (i) the rational exposure of the palpable falseness of his morbid beliefs; and (ii), as a control condition, the discussion of the handling of his guilt feelings. Each kind of discussion was held eight times, in a balanced order. The strength of the patient's paranoid beliefs

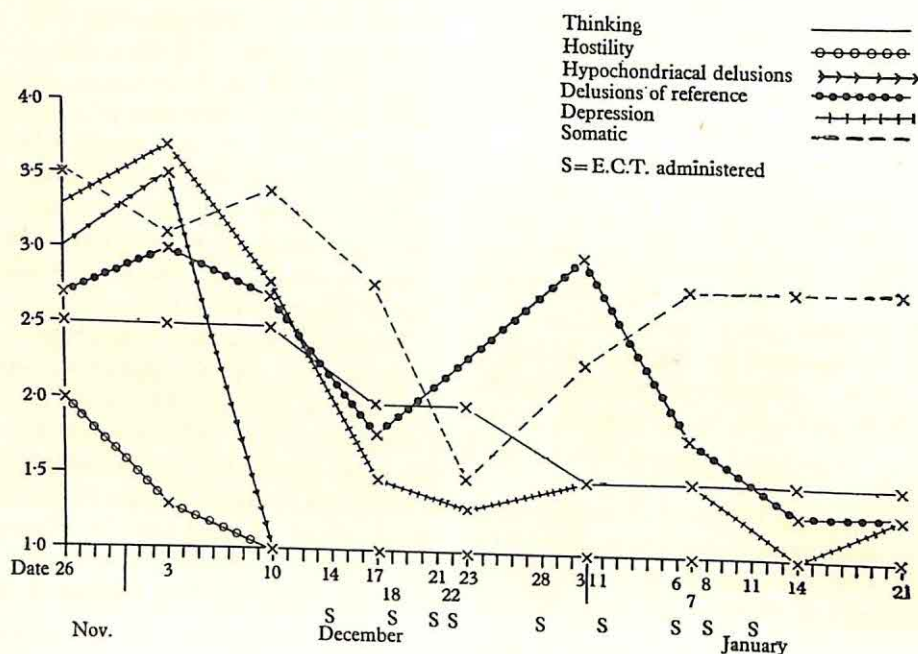


Fig. 1

indicated by the F ratio for the class-occasion interaction which was 1.506. This was significant at the 0.001 level. We have here an indication of the validity of the initial classification of symptoms. One of the aspects of this finding is that the illness, during its course, appears to change its content quite considerably. The illness on 31 December is quite different from the illness on 3 December. The changing character of an affective illness, if confirmed, might be a fact of some importance.

Discussion

The personal questionnaire is primarily intended for use in the intensive experimental

was measured, before or after each discussion, by an elementary form of personal questionnaire. These beliefs became less strongly held after the discussion of their falseness, and more strongly held after the discussion of guilt feelings.

The personal questionnaire could be used for 'group-centred' as well as for 'individual-centred' research, i.e. it would be possible to make comparisons between individuals, either in respect of similar groups of symptoms or of the whole symptomatology, in terms of their ratings by the patient on the Affect Rating Scale. Such a method of scoring is analogous, in principle, to the scoring of a subject's

responses in an individual vocabulary test. In such a test the actual responses are peculiar to the subject uttering them, but they are scored in terms of an assumed dimension of quality of definition, the designer of the test usually providing examples of each assumed quality. In the case of the personal questionnaire the subject's responses are scored in terms of a standardized scale measuring unpleasantness of experience. It would, for example, be possible to compare an experimental group with a control group for changes in unpleasant symptoms, each subject being measured by means of a personal questionnaire constructed specially for that subject.

Dr F. Post has suggested that the personal questionnaire might be useful in the following circumstances: (i) for clinical purposes with patients whose assessment depends on questioning the patient, on many occasions, about his mental state, and (ii) where it is necessary to follow, in quantified form, the detailed and clinically relevant responses of the patient to a treatment which is under investigation. Methods are at present not available for such purposes.

It should be noted that, just as the patient's symptoms are calibrated for unpleasantness of experience in the present questionnaire, it would be possible to develop methods of calibrating a patient's responses in accordance with other variables. For example, the patient's statements could be calibrated for severity of illness, by having the patient's psychiatrist rate the statements for severity of illness in terms of a scale of severity which had been previously standardized on psychiatrists.

There are two outstanding defects in the present form of the personal questionnaire.

In the first place, one form of irrelevant response set, the set to make oneself appear more or less ill than one really is, has not been controlled. This is, of course, a difficulty which is inherent in all 'question-answer' procedures. In the second place, it is not yet clear how far current methods of statistical analysis, which are based on the complete independence of all the relevant observations from each other, can be applied to observations made of the single case. The work of Senders & Sowards (1952) indicates that this might not be a serious problem when the subject is able to discriminate clearly between the stimuli presented to him. These are matters for further investigation.

In spite of these and other difficulties, it would appear methodologically justifiable to use the personal questionnaire in its present form for research and clinical purposes. It is, after all, a controlled method of doing what the psychiatrist does when he takes a mental state, with all the advantages and disadvantages that are inherent in the introduction of controlled methods. Once, however, a controlled method of observation is developed, it becomes possible to carry out systematic experimental enquiries into its implicit assumptions and sources of distortion. Such enquiries are now in progress.

It is not possible to discuss fully, in a short paper, the methodological and practical implications of the personal questionnaire. It is hoped, however, that sufficient material has been provided in this paper to show that it is possible to combine the ideographic and nomothetic approaches. Such a combination seems to be essential for the further advance of clinical psychology, both as an applied and fundamental science.

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Grouping and tranquillizers in the chronic ward

By B. COOPER*

Despite a renewal of therapeutic optimism in the past decade, the problem of the long-stay mental hospital patient remains largely unsolved. New methods of treatment have tended rather to increase speed of recovery in the case of good prognosis, than to improve the outlook for the deteriorated patient (Freyhan, 1955).

The advent of tranquillizing drugs has introduced an era of pharmacological treatment, in which more conservative methods may suffer unwarranted neglect. Rathod (1958) found that behaviour in two refractory wards improved when a programme of intensive occupational therapy was instituted, despite simultaneous replacement of tranquillizing drugs by placebos. Robin (1957) noted a deterioration in chronic psychotic patients when occupational therapy was withdrawn, despite a great coincident increase in the use of tranquillizers; he pointed out that the increased drug bill would have more than covered the cost of an extra occupational therapist. Blair & Brady (1958) attributed improvement of the chronic wards in recent years to two main advances: on the one hand to group training and the institution of a more liberal and permissive regime, and on the other to the use of the new drugs, particularly chlorpromazine.

While much can be achieved by any planned programme of work and recreation, the most promising attempts have been those designed to develop interpersonal relations, both among groups of chronic psychotic patients, and between the patients and their nurses (Cameron, Laing & McGhie, 1955; Merry, 1956).

Such attempts may however prove laborious and difficult to extend to large numbers of patients, and it seems desirable to determine their value compared with that of the easily administered tranquillizing drugs, and to discover whether the different methods of approach serve to produce the same qualitative improvement.

It is also possible their effects are such as to produce a greater total improvement when given jointly than singly.

In the experiment described in this paper (carried out two years ago), the effect of chlorpromazine on a group of female chronic schizophrenic patients was compared first with that of group-nursing alone, then with that of group-nursing and chlorpromazine combined. Chlorpromazine was regarded as the tranquillizing drug of choice. Most workers have found it of real value in the treatment of disturbed psychotic patients (Anton-Stephens, 1954; Charatan, 1954; Elkes & Elkes, 1954). Comparative studies have in general shown it to be as effective as, or more effective than, other tranquillizing drugs (Shepherd & Watt, 1956; Thorpe & Baker, 1956; Fleming, Spencer & Whitelaw, 1959). Salisbury & Hare (1957) found it superior to Ritalin, a stimulating drug, even for retarded and withdrawn schizophrenic patients.

A large female chronic ward was chosen for the experiment. It had been known formerly as a refractory ward, and though with improving hospital standards this term had fallen into disuse, a number of the patients still presented difficult nursing problems. Of a total population of 56, 36 were long-stay psychotic patients, mostly schizophrenic. The remaining 20 were deteriorated senile patients, introduced to the ward some time previously for habit-training. The atmosphere of the ward was typical of many described. Patients sat unoccupied or paced restlessly up and down. Most were solitary, withdrawn and hallucinated. Some had periodic noisy and aggressive outbursts. Minor assaults were frequent, and various anti-social or harmful practices were in evidence. One patient would scald herself with boiling water at any opportunity, another spent hours picking out window-panes, while a third scavenged in the swill-bin. Despite a programme of habit-training, incontinence was frequent. The outer doors were locked and several patients were regarded as persistent escapers, needing constant observation. A good deal of paraldehyde was administered

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both day and night. Most of the patients were under certificate; few were allowed in the hospital grounds unaccompanied and none outside the hospital. Exercise was confined mainly to an enclosed garden shared with patients from other wards. Patients had little personal property, even clothing. Most were given sweets and cigarettes, but never handled cash.

METHOD

Twenty patients were selected, the only criteria being (1) that the accepted diagnosis was chronic schizophrenia (sometimes recorded as 'delusional insanity' or 'secondary dementia'), and (2) that the patient had not had, nor was currently having, a course of any tranquillizing drug.

The twenty patients were then divided alphabetically into two groups of ten, designated respectively A and B. The distribution was as shown in Table 1.

Table 1

	A	B	A + B
Mean age in years	54.2 (44-66)	54.5 (39-67)	54.4 (39-67)
Mean duration of hospital stay in years	20.5 (11-30)	22.7 (6-29)	21.6 (6-30)

The experimental period was divided into three phases:

(1) A preliminary period of six weeks during which neither group received any systematic treatment.

(2) A period of twenty-four weeks during which patients in group A received chlorpromazine, while those in group B were given no drug treatment but had a vigorous programme of group activity under the care of two nurses specially detailed.

(3) A further period of twenty-four weeks during which patients in group A continued their course of chlorpromazine, while those in group B continued their programme of group activity, and in addition were given a course of chlorpromazine.

All twenty patients were rated at weekly intervals on the Barrabee-Hyde Social Adjustment Scale (Greenblatt & Solomon, 1953), the rating being carried out by the two ward-sisters. In addition, a careful clinical assessment of each patient was made at monthly intervals.

The treatment regime and progress of the two groups are described separately.

Group A

The patients in this group had no organized programme of activity, and apart from their drug treatment were not considered separately from other patients in the ward. Their occupation and freedom of movement were determined for each patient individually, on the basis of clinical progress. They were allowed to take advantage of any benefits arising from the steady improvement of ward conditions, such as the opening of the ward doors, and in some cases attendance at the newly established hospital factory.

Most patients took chlorpromazine readily in the form of a syrup. It was accepted even by the more disturbed and negativistic patients, and its administration presented few difficulties. The maximum daily dosage employed was 300 mg., except in one case when it was raised to 600 mg. (but without added benefit). In several cases patients became increasingly inert and drowsy on this dosage, and were better on a maintenance dose of 100-150 mg. daily. Parkinsonian symptoms were common, but mild and easily reversed. Three patients developed skin eruptions which cleared up after two or three weeks despite continued administration of chlorpromazine. Most of the patients gained weight, and a few became frankly obese. None developed jaundice, and no serious side-effects were observed. In general chlorpromazine proved both easy to administer and relatively harmless.

In most cases an improvement in the patient's mental state was apparent in the first month of treatment and gradual improvement continued during the subsequent months; in two cases, however, there was a small initial improvement followed by a much more marked 'jump' several months later.

Group B

The programme of group activity for these patients was based largely on that described by Cameron *et al.* (1955). Two nurses were selected to take charge of the group, and worked alternating shifts. The ten patients shared a small dormitory and ate all their meals together in an annexe of the ward, separately from the other patients, and supervised by their own nurses. The latter also supervised their dressing, toilet and ward-chores.

A small room adjacent to the ward was taken over for occupational therapy by the group. It was furnished simply, from surplus ward stock, and nothing was spent on new furniture or renovation. The patients were encouraged to improve the room by their own efforts, and were occupied in making lampshades, rugs and curtains. An old wireless-set was installed. A looking-glass was provided, and the patients were encouraged to attend to their appearance, to do their hair and apply cosmetics. A good deal of freedom was allowed each patient in choosing occupations. Drawing-paper, crayons, poster-paints and modelling clay were supplied, as well as playing-cards, draughts and dominoes, picture-books and magazines. At the same time the patients were encouraged to engage in useful activities, and to join in conversation. Tea was provided in the room, and members of the group were persuaded to serve one another and to pass round sweets and cigarettes. The programme was varied by walks in fine weather, and the group attended all hospital social functions.

As the patients showed improvement, their freedom of movement was increased. Initially the door of their room was locked, but this soon became unnecessary and patients were allowed to make their own way to the hospital shop. Each was now given a small weekly allowance in cash. For some it was the first time for many years that they had handled money, and the effect was striking. At first they showed little awareness of its value and purchasing power, and would throw or give away coins. However, they soon began to appreciate money values, and to purchase spontaneously such articles as lipstick, face-powder and hair-grips. They also consented fairly readily to save money for outings.

At first restricted to the hospital grounds, the group began after a while to go on shopping expeditions and walks to the local parks. They were also able to attend evening cinema shows, normally reserved for the 'better' patients. Several outings were arranged, including a charabanc trip, tea in a restaurant, and blackberry picking. At Christmas the group held its own party. All these activities were paid for by the patients from their savings. To develop their awareness of personal identity they were provided as far as possible with individual garments marked with their names, and encouraged to take care of these. During the last three months of the experi-

ment it was decided to switch the group from simple handicraft occupations to the 'industrial therapy' which had become available in the hospital. They were given a simple repetitive task of assembling ball-pens, and paid at piece-rates. On the whole the group patients responded surprisingly well to this work, but the supply was sporadic and insufficient for any conclusion to be drawn as to its effect on their behaviour.

The grouping programme imposed from the start a certain amount of strain on both patients and staff, and apart from a marked improvement in the very early stages, the effect on the patients was rather less obvious than that of drug treatment on group A. However, most of the patients quickly accepted their new routine. They would assemble spontaneously to go to their room, and remain there without demur. Two patients became at different times restless and agitated, making comments such as 'I don't want to stay in this wicked place'. All the members became more reliant on their own nurses, and simultaneously less responsive to the ward-sisters and other nurses. They were also strikingly more difficult to manage when one of their own nurses was away on leave. Throughout the experiment none of the group patients made any attempt to abscond, even when allowed outside the hospital alone. (It is interesting to note, however, that within two weeks of the experiment being terminated, one patient formerly regarded as a persistent absconder did, at considerable risk, escape through an upper-floor window.)

The effect of the grouping programme on the two nurses in charge was a mixed one. There could be no doubt that they had become more attached to their patients, and more aware of them as individuals. Moreover their initial pessimism regarding the problems of the chronic psychotic rapidly disappeared. On the other hand, they continued to find the grouping programme a greater strain than ordinary ward duties, probably because of their increased sense of responsibility. In the first half of the experiment they repeatedly asked that their patients should be given chlorpromazine, since they could observe the beneficial effects on the group A patients. Generally speaking, the ward-sisters proved more enthusiastic for the grouping programme than the nurses who carried it out.

No other systematic treatment was given to patients in either group, except that during the

year of the experiment one member of each group was given a course of modified electro-convulsive therapy, in each case because of a phase of severe depression with retardation and difficulty in feeding. Each showed a moderately good response.

RESULTS

The results of the weekly ratings were averaged for groups A and B and average figures were obtained for the preliminary period of six weeks and for consecutive four-weekly periods during the experiment. The results are shown in Table 2. Statistical analysis of the results in Table 2 and Fig. 1 (using analysis of variance) did not show a significant difference between the levels of improvement of the two groups, either in the first 24-week phase, or over the total period of the experiment. The apparent trend, however, was that of a fairly steady initial improvement in both groups, more marked in group A. This was followed by a period during which little progress was made. Then, in the second phase of the experiment, subsequent to group B patients commencing chlorpromazine treatment, there was an acceleration of progress which affected group A almost equally. This second period of improvement coincided with a general improvement in the ward environment, including opening of the ward doors, and increased occupational facilities.

The Barrabee-Hyde scale is subdivided under four headings: self-care, co-operation, productivity and sociability. The rating averages for each of these subdivisions, for consecutive 12-weekly periods of the experiment, is shown in Table 3. From this table it can be seen that in both groups

the ratings for each subdivision show a comparable increase during the course of the experiment. The improvement is most marked in productivity, which was given the lowest rating at the commencement, and least in self-care, which had the highest initial rating. This is true for both groups. Moreover, the amount of scatter among the individual scores was approximately equal in the two groups.

The monthly clinical assessments, which coincided fairly closely with the rating-scale results, showed three group A patients greatly improved, four moderately improved and two slightly improved. In group B two were greatly, four moderately, and three slightly improved. No single clinical feature, such as disappearance of thought disorder, or of hallucinations, was more marked in one group than in the other.

DISCUSSION

The results obtained show no significant difference in the degree of improvement obtained with the two methods of treatment, and no detectable difference in the kind of improvement produced by each method. There was, however, a discernible trend for a more rapid improvement in group A in the first half of the experiment, while in the second half there was an accelerated improvement in group B (which did not, however, overtake group A). This suggests that the administration of chlorpromazine was at least as effective as the method of group-training employed, either alone or in addition to chlorpromazine.

If this represents a true finding, it suggests that under prevailing conditions the administration of

Table 2

4-weekly periods ...	0	1	2	3	4	5	6	7	8	9	10	11	12
Group A	3.2	3.2	3.4	3.6	3.9	4.0	4.0	3.9	4.0	4.1	4.2	4.3	4.3
Group B	3.2	3.4	3.3	3.5	3.6	3.7	3.7	3.7	3.8	4.0	4.0	4.1	4.1

Table 3

12-weekly periods ...	Group A				Group B			
	1	2	3	4	1	2	3	4
Self-care	4.3	4.5	4.4	4.8	3.9	4.1	4.3	4.4
Co-operation	3.9	4.5	4.5	4.6	4.0	4.2	4.4	4.6
Productivity	2.4	3.5	3.5	3.9	2.8	3.3	3.3	3.8
Sociability	2.9	3.5	3.4	3.9	2.8	3.0	3.2	3.6

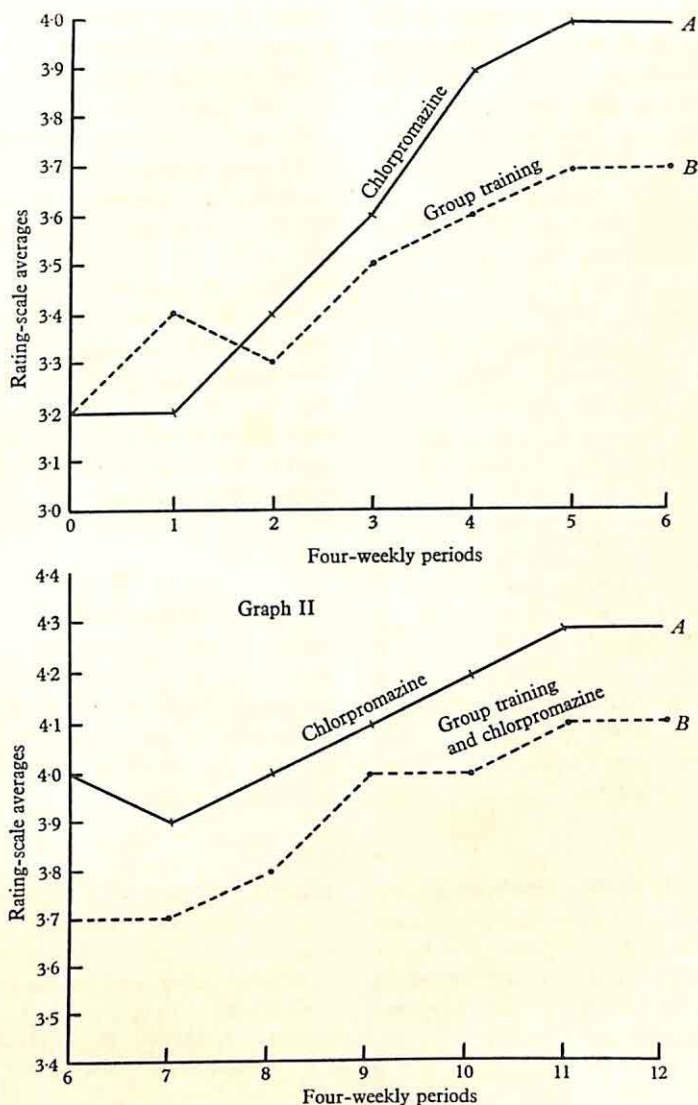


Fig. 1

chlorpromazine, or other tranquillizing drugs, must be regarded as a more important item of treatment than the type of group-activity programme described, the latter being more laborious and stressful without being more effective. It is quite possible, however, that this conclusion may apply only where certain conditions prevail, e.g. where a fairly high standard of nursing care existed previously, and where facilities for therapeutic occupation were available. Conversely, 'group-assignment' nursing and group-activity programmes may be more effective where a more

liberal nursing establishment allows greater individual attention to patients, or where money can be expended to produce a pleasant environment.

The grouping programme used for this experiment was designed to make no extra demands on medical and nursing staff, and to require no extra outlay of money. This deliberate limitation of time and money expenditure may have been at least partly responsible for the fact that the results obtained, though positive, were less striking than those of some other workers.

It may be that a general improvement in ward

atmosphere, which can be obtained partly by the systematic use of tranquillizing drugs, and partly by 'administrative therapy' (Clark, 1958), will diminish the need for group-training of chronic patients, and that the next major advance will be achieved by other methods now being developed, such as provision of paid work under sheltered conditions, and increased day-care facilities. More investigation is needed of the effects of such programmes. There is a great need for increased knowledge of the relations between all the various modes of treatment in use and current changes in the pattern of the chronic mental ward. In the present state of knowledge any effective treatment of schizophrenia is empirical, and prejudices arising from fixed aetiological concepts must be carefully avoided.

SUMMARY

The problem of the chronic mental ward remains largely unsolved, and there is still no generally accepted therapeutic regime. Advances in recent years have been attributed mainly to group training and the use of tranquillizing drugs. An experiment is described in which these two methods of treatment were employed, separately and together, on two groups of chronic schizo-

phrenic patients, and the results measured on a rating-scale and compared.

Considerable improvement was obtained with both methods. There was no significant difference in the results, but patients treated with a tranquillizing drug (chlorpromazine) tended to improve more rapidly than those treated by grouping only. Patients treated by both grouping and chlorpromazine did not improve more rapidly than those treated by chlorpromazine only.

The inference is drawn that under prevailing chronic ward conditions the systematic use of tranquillizing drugs should be regarded as the first line of attack, while the effects of social methods such as day-care and sheltered workshops should be investigated for the possibility of further improvement.

ACKNOWLEDGEMENTS

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MELANIE KLEIN

Photo: Jane Brown

(Facing p. 163)

Obituaries

Melanie Klein

30 March 1882 to 22 September 1960

By T. F. MAIN

When Melanie Klein died in London in September 1960 at the age of 78, her greatness was already assured. For forty years the established world of medical psychology had been troubled by her steady, uncompromising search for deeper truths, and had variously greeted her findings with interest, admiration, even adulation; and doubt, criticism, even anathema. Her work led to controversy, but none could ignore it nor deny her creativeness, single-mindedness, courage and stature. It still arouses in the world of psycho-analysis the greatest fervour, for in her life she trod boldly where none had been before, and invited others to follow.

She made and demanded far-reaching revisions and extensions of psycho-analytic theory and training, and from her novel technical approach to the psychoanalysis of children she produced concepts, penetrating and unifying, which led later to technical changes in the psychoanalysis of adults. Her work led her inexorably to challenge not only ignorance but existing knowledge in ever-increasing amount, while the variety and richness of her contributions compelled attention. Some, dazzled by her work, have put it beyond criticism, and have their counterpart in others who have scorned all of it.

Her ideas had such scope, depth and complexity that they challenged established thought, so it is not surprising that sincere doubts arose about some of her most gifted formulations and her technique. Moreover, the controversies which surrounded her led to partisan groupings which have made a true evaluation of her work the more difficult. Yet the controversies themselves are not about trivial but about fundamental matters. Of her

size, her genius, there is no doubt; medical psychology is forever enriched by her life; and it is certain that following Freud her claims to greatness among psychoanalysts are imperishable.

Her gifts, her daring, her restless search for the truths about early states, her amazing sensitivity and formulative skill, were of unusual quality. She was no practitioner of scholarship, but had a freshness and freedom of thought which was with her to the end, while her capacity for fructive conceptualization gives her writings a quality of dazzling imaginativeness and a shocking newness. Her thought is that of the break-through scientist aware of but unfettered by existing discipline, who brings to existing facts a new vision by an act of creative art which unifies and illumines afresh.

Her writing is her most enduring monument but is beset with flaws, and it often fails to convey the love she had for patients in their struggles and which drove her not to sympathize but to think the harder about their inner struggles and to sharpen the only aid which she believed could help them—interpretations of their deepest anxieties. It contains imaginative statements insufficiently supported by evidence, clauses which represent earlier condensed thought but which read as dogmatism, and admixtures of metapsychological, clinical and experiential terms which give logical weaknesses which a university education might have avoided but which hide the very logic she sought and used. Her style was poorly structured, now tight and meaty, now discursive and repetitious. It does justice to her vision and her talent but not to her painstaking searches for checking of ideas.

She was at her best in clinical case discussions where she could show her regard for her listeners, her gifts of simple exposition, her directness and depth of understandings, her skilful handling of the interplay between clinical findings and theory, her readiness to discuss, explain, modify.

She was, however, a passionate scientist. Sensitive to any basic criticism of her findings, she reacted decisively, distressed, hurt, fierce and unforgiving. The years of painstaking cost her dear, she arrived at convictions about the truth of her findings and she would not have them denied or lightly regarded. All her life she promulgated her ideas against critics, and although she could enjoy scientific polemics and share this enjoyment with those who agreed with her, she valued her work too highly to allow it to be undervalued by others. Polemics for her was not a game and it was therefore not possible for her to be truly at ease with those who had reservations about her work. But with her friends, or with an untutored audience, she showed an astonishing capacity to order simply some of the most involved problems of human behaviour.

This was no ordinary life, and her entry into the world of psychoanalysis is itself noteworthy. It would be almost impossible in these days of regulated societies, but it was remarkable even then. Sprung from an intelligent middle-class Jewish medical family, she was a Budapest housewife in her thirties, with a husband and young children and without medical training or academic degrees, when she sought analysis with Ferenczi during the First World War. Her analysis lasted some years, and during it she began to observe and give analytic interpretations to a distressed child relative, with whom she was on close terms. (One can speculate on how far the later reflexions on this unusual analytic relationship led to her later enduring view that the role of analyst must not be contaminated by that of reassurer.) Ferenczi, that most liberal of experimenters, recognized the talent in his patient and encouraged her to continue to work in the new field of child therapy, and from

then on she devoted her life to psychoanalysis and the earliest stages of human development. She was present at the Budapest Congress of Psycho-Analysis in 1918 and in July of the next year she read her first paper 'The Development of a Child', later expanded and published. Towards the end of 1919 she became a member of the Hungarian Psycho-Analytic Society and in December 1920 she read there 'A Contribution to Child Analysis'. Two months later she delivered her paper 'Child Analysis' in Berlin. From then on she never let up. These papers show her developing technique, her passionate application of psychoanalysis to the new field of childhood, and her sensitive search to understand at depth childhood's earliest anxieties.

It was the time of the late analytic dawn, in which Freud's followers, a small group, were excitedly charting the unconscious. Melanie Klein joined them and was one of the very first to explore the minds of children. At The Hague in 1920 she met Freud and some of his followers, Abraham, Deutsch, Groddeck, Hug-Helmuth, Jung, Reich, Roheim and others whose names are today a by-word. In those days when short didactic analyses were regarded as sufficient for training, it is possible that she had had longer personal analysis than any. Certainly none exceeded her in enthusiasm.

In 1921 her husband went to Sweden and she moved with her family to Berlin at the invitation of Abraham, who too had noticed her great promise and who welcomed her to work as the first Child Therapist at the Berlin Psycho-Analytic Institute, which had opened the previous year. For the next five years she worked there steadily, laying the foundations of her technique and describing the complex role of oral aggression in childhood development and the linked mechanisms of introjection and projection. This work flowed from the earlier insights of others, but she was impressed by the universality and complexity of aggressive impulses and laid new stress on them, emphasizing their dynamic nature and results. Much earlier Freud had made his painful

discovery that his women patients' memories of childhood seduction were derived from instinct-impelled fantasies. Melanie Klein, in the more naked and compelling field of child analysis, followed this courageous path. Then and always she explored to the full the ways in which the drives which lie behind love and hatred are projected and so distort the perception children have of their parents, and of part objects, and give rise to the living fantasies which are decisive for development. On the basis of these distortions of the child itself and the world around it, she built the beginnings of what was later to become a consistent body of psychoanalytic hypotheses about the nature of the internal world of human beings. Unremittingly all her life she sought to understand the instinct-driven fantasies which lie behind even the earliest beliefs and feelings, to a degree never attempted before. She studied the defences against sadism, and found sequences of anxiety, projection, anxiety, introjection, anxiety, re-projection, anxiety, re-introjection, in the greatest detail in the transference. She described the terrors arising from the need to protect the self and the loved objects from external and internal dangers, and the fate of the ego in such struggles, in a way none had done before.

The five years in Berlin were hard and turbulent. Her findings about the horrifying and unrealistic nature of her young patients' fantasies were new, and particularly emphasized orality and aggression, and they gave rise to argument and dissension among many of her colleagues, especially those who worked with adults. Her own emphasis on the death instinct and its projection, as major determinants of what is experienced at the earliest stages was, and still is, out of line with the views of those who were occupied rather with what may be called autonomous libidinal and ego development, ego defences, and the effects of external traumata, while her insistence on the feasibility of child analysis without any educative or reassuring concomitants was rarely accepted. Anna Freud's technique and findings in Vienna were of course in

contrast to Melanie Klein's. The Berlin scene included Alexander, Felix Brühl, Deutsche, Eitingon, Fenichel, Edwards and James Glover, Gross, Karen Horney, Muller-Braunschweig, Payne, Rado, Reich, Sachs, Sharpe, Simmel, and in this company controversy was of an informed order. She needed all her courage and pugnacity to persist in the face of passionate criticism, and even personal contumely. The early twenties were also a time of painful personal stress for her, and in 1923 she and her husband divorced.

But in all her difficulties a second great man, Abraham, who was President of the Berlin Society, supported and steadily encouraged her. In 1924, in spite of repeated misgivings about the wisdom of engaging in analytic relationships in a small society, he was persuaded by her to do further analysis of her. The blow to her of Abraham's death at the end of 1925 was particularly severe, and all her life she referred to him with admiration and gratitude.

Controversy and heavy criticism remained however, and anti-semitism was growing in Berlin. Her family was growing up and no longer needed her so much. Thus when in 1926 Ernest Jones asked her—following her delivery in 1925 of lectures in London—to work in the British Psycho-Analytic Society, she gladly accepted and settled there with her youngest son, to continue to work and develop her ideas in child analysis.

Jones was the third great man to recognize and to sponsor her talents, and with his support she continued to work with children. British analysts wanted to learn from her about child analysis and she undertook the supervision of their child cases. Edward Glover, Susan Isaacs, Joan Riviere, particularly welcomed her ideas but she found much support also from M. N. Searl, Ella Sharpe, Sylvia Payne, Marjorie Brierley and others, and by the early thirties she had begun to analyse adults as well as children and to develop her technique of adult analysis, which sprang from her findings about the earliest internal anxiety situations.

Her work developed in scope and depth,

and now she made regular additions to her earlier concepts, and wrote prolifically. The early Oedipus Complex, the early Super-ego, her concept of the Depressive Position, and the beginnings of her work on psychotic processes occupied her in turn. Controversy again grew however. Her technique, to which she was led by her findings about the fluctuations of mood caused by immediate introjection and projection processes, involved rapid and frequent interpretations about the earliest anxieties involved, and was out of line with the views of other analysts; the terms by which she described her work involved concepts which were not universally accepted; and her need to teach her views and methods to others was in question as a danger to classical teaching. By the late thirties the Viennese analysts, whose developing work with ego-psychology had led them to different conclusions about the child's capacity for early experience, lent their voices to the opposition in London.

The ensuing decade of controversies cost Melanie Klein the full support of many British psycho-analysts who had earlier welcomed her, and she began to draw around her a group of pupils who became later known within the British Psycho-Analytic Society as the 'Kleinians'. This group, at first small, could work with her concepts and support each other without serious controversy, and yet could lay their findings before their psycho-analytic colleagues.

It is true that some of the controversy proper, important and even essential for science, took personal forms. Melanie Klein was at its centre, doughty in defence of her own work and well able to give as good as she got, but nothing interfered with her work.

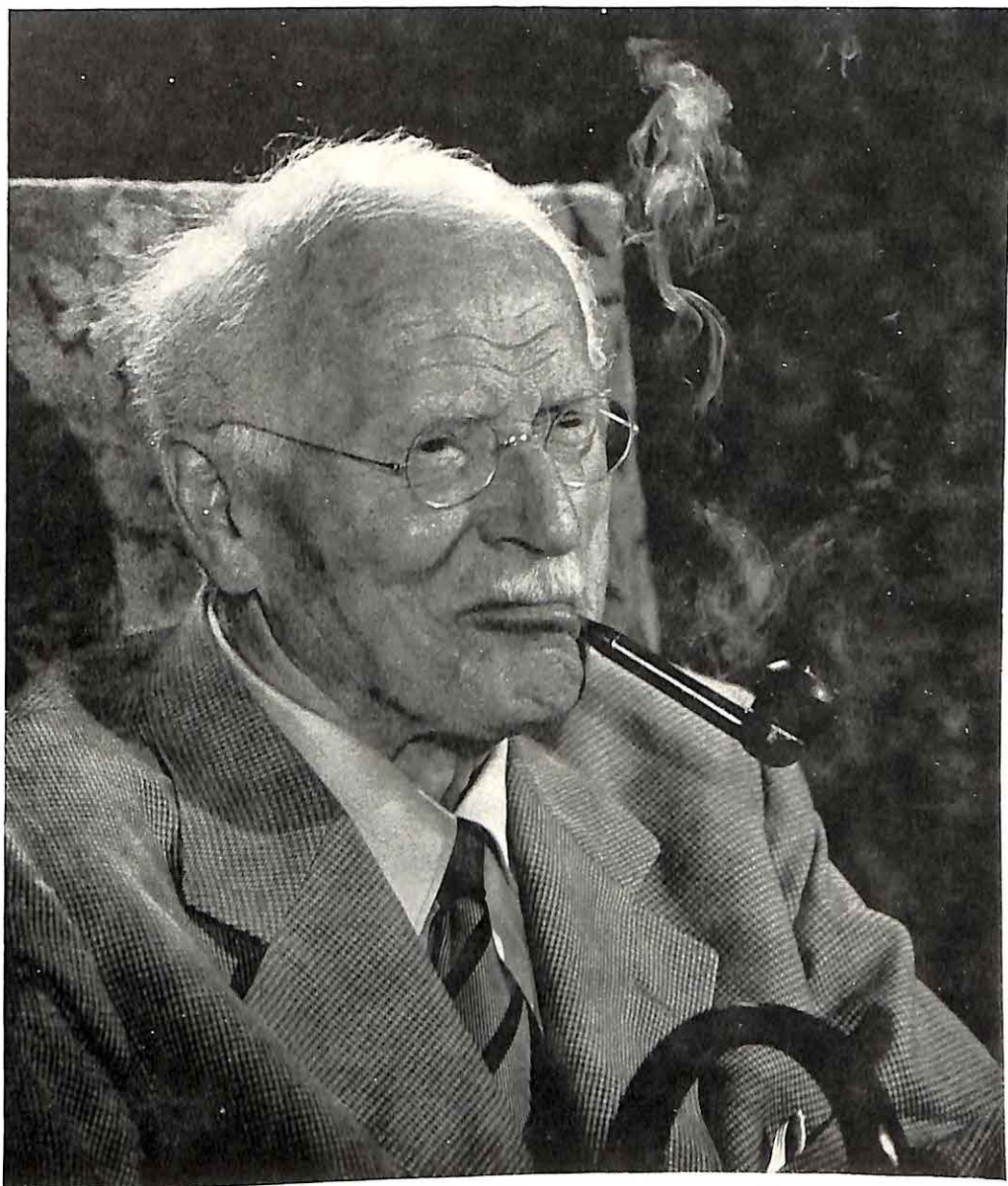
She treated her last child patient in the late forties, but until her death retained links with child analysis by supervising many students, who used her technique and conceptual systems. Her main work now was to teach and analyse psychoanalytic students, to write and to treat adult patients. Her creativity remained to the end at the flood, as her writings show; her study of schizoid mechanisms, her

formulation of the paranoid-schizoid position, her work on infantile oral envy show her capacity for major leaps of thought. At the time of her death she was preparing one of the many papers she read to others.

In the last period of her life, with the thinning of her own generation, she supported and was supported by her earlier pupils. These, now matured and teaching others, have worked with her ideas and pursued their implications, not only in the field of neurosis and character disorder but in psychosis, in industry and in sociology. She slowly arrived at a serenity which allowed her a quiet pride in her accomplished work. Those who knew her only for the last decade would see only a charming old woman whose increasing frailty contrasted with a sharp mind and an enduring femininity and freshness which shone from her, and which allowed only occasional hints of the militant power and verve of her earlier years. Her pleasure in living showed itself in many ways, none more infectious than the chuckle which bubbled out of her, even at scientific meetings, and which could reduce her to tears and helplessness. She sought peace from controversy in the company of those who sympathized with her work and whom she could count on to extend it and was happy with young people who learned from her. She leaned much on her younger friends and liked to be accompanied by one.

Her life was a struggle to understand the deepest origins of human anxieties and to obtain recognition for her findings. The compassion and courage she brought to this were allied to a pugnacious determination, which alone would have guaranteed stature for her in any field. But her singular gifts for making contact with the unconscious were there in greatest measure and it is these, shining through her work, which gave it uniqueness.

Several critical appraisals of her work were made during her lifetime and no doubt the future will see more, for her work demands heart-searching attention. But despite all criticism we can be sure, at her passing, here was greatness.



C. G. JUNG

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(Facing p. 167)

C. G. Jung

26 July 1875 to 6 June 1961

By MICHAEL FORDHAM

Amongst the memories of C. G. Jung, there is one which has remained consistently in my mind. It is of a tall, ageing and dignified figure entering the church at Kusnacht, followed by a seemingly endless stream of children, grandchildren and great grandchildren. The occasion was the funeral of his wife.

The dignity of his bearing stemmed from all that was best in him, and was manifest also in the recurring despair of the months before his death: he was not understood and had failed, he even tragically thought that the essence of his work, in which he so firmly believed, would go unheeded.

A big man, physically and mentally, there seemed no end to his personal and creative abilities whether they found expression in his research, or in the vivid wit and humour with which he would entertain his guests. His published works pay tribute to his intellectual productiveness but he will be remembered for more than this: he engraved himself in the hearts of those numerous people who, like myself, have been close enough to love his generosity and appreciate his unfailing sympathy with human distress whether personal or collective. Those who knew this were often astonished and incredulous at finding how unfair he could occasionally be in his judgement of others. This trend in his character, the violence which he feared, as he said in his recent television broadcast, makes his excessive sensitivity to criticism and the way he was hurt by it, more understandable.

Amongst the epithets used against him there were two which are of particular interest, he was called a seer or a mystic. The injustice of it angered him for he had the makings of

both, and was prevented from becoming either by his self-analysis and his scientific attitude. It is of much interest that this conflict area in him did not impair his effectiveness in controversy in which on the contrary he could be effective, brilliant and subtle.

However inevitable the current idealization of him may be as part of mourning, it is singularly out of place, for he required us to see him as a whole. His concept of the self defined as a compound of opposites each of which it transcends shows us what he intended. His aim was completion by which he meant that it is neither what a man ought to be nor what he aspires to, but what he is as a whole that counts. Ignoring Jung's imperfections therefore violates the meaning of all he had done.

One of the first to penetrate into the psychodynamics of schizophrenia, he was probably the first to realize what this meant to himself and to anybody following in his footsteps: coming to know deintegrative and disintegrative processes in his own nature. There is little doubt that these led him to use the technique of active imagination on himself, and so make conscious an inner world on which he worked unceasingly for the rest of his life.

Objectively and apparently apart from himself, he studied first the reparative processes in psychotic delusions and hallucinations, next he related these to himself and to the wide variety of patients in his analytic practice. But he did not stop there, he went on to show how his material could be built into the processes manifest in religion; so uncovering a dynamic, historical and emergent development in civilization whose aim he defined as realization of the self.

He ruthlessly pursued his scientific aims in which he was more of a pure scientist than is understood: in a constant search for new

* Obituary address to the Medical Section of the British Psychological Society, 28 June 1961.

knowledge he would investigate any clue however valueless it might seem. At the same time, though sparing in his theoretical constructions, he could be daring and revolutionary in them should his observations demand it. He could violate well-founded scientific theory but it was not science as the technical pursuit of knowledge, but scientism which he attacked especially when used in an attempt to destroy his chosen field of study: the inner world of archetypes.

His researches have already contributed extensively to scientific knowledge, have stimulated innumerable research workers in a wide variety of fields and have laid the foundations for training in analytical psychology. Yet the potentialities of his researches are not yet exhausted by a long way, indeed, the best monument that can be raised to Jung's memory is to make use of and develop his work rather than let it be passively accepted and sterilized. The final justification of his long life of labour will thus be increased by its continued fertility.

Jung's death marks the end of an era. He was the last of the brilliant and courageous

pioneers who laid the foundations of psychoanalysis and then of analytical psychology. His name is still almost automatically linked with that of Freud as most nearly Freud's equal, and if his main life's work was in the end to be founded on a personal and scientific incompatibility with Freud, there are those who believe, like myself, that this was a disaster, and in part an illusion, from which we suffer and will continue to do so until we have repaired the damage.

What the work of these men and women meant is scarcely understandable to us today when a basic knowledge of psychopathology, and organized training in its application is available; when so many features of our civilization, religion, art and the foundations of our social structure have all been significantly illuminated by it. They, and Jung was essentially a leader amongst them, created almost out of themselves, through struggle and conflict, a new science with endless ramifications.

As one of their heirs, joined I am sure by countless others, I welcome this occasion to mourn C. G. Jung, the last of them, in sadness and gratitude.

Phases of patient-therapist interaction in the psychotherapy of chronic schizophrenia*

By HAROLD F. SEARLES

At the end of three years of doing intensive psychotherapy with chronically schizophrenic patients, I found myself occupied, for a comparatively brief period, with the question of whether I should go ahead and devote myself, for an indefinite number of further years—perhaps for the whole remainder of my professional career—primarily to this line of endeavour. I decided in favour of doing this, out of a feeling of having found myself in the course of my personal analysis, in the course of these early years in the crucible of the intensive psychotherapy of schizophrenia, and in the course of my developing marital-family life. The question of whether I am a human being, possessed of the feeling-capacities which activate human beings, had been affirmatively put to rest, and I felt able now to approach this psychotherapy in a new and workmanlike spirit, sure that my basic potential for this work was there in me, and curious to see what truly professional *techniques*, quite beyond the countertransference-ridden flounderings of the neophyte, one could develop in grappling with this remarkably complex job that clearly needed doing.

The nine years which have passed since then, while confirming for me the validity of that shift in my feeling-orientation, have none the less forcibly brought home to me the realization that the 'technique' of psychotherapy with schizophrenia is best spelled out in terms of an evolutionary sequence of specific, and very deep, feeling-involvements in which the therapist as well as the patient becomes caught up, over the course of what has emerged, for

me, as—in necessarily broad and schematic terms—the 'normal' and predictable over-all course of psychotherapy with the chronically schizophrenic person. This paper, then, will attempt both to highlight the crucial role of feelings in the therapeutic relationship, and to delineate what I have found to be this 'normal' over-all pattern of the psychotherapeutic course which that relationship follows over the years of the patient's treatment.

The therapist's feeling-involvement in this therapeutic work is, for various reasons, a deep one, and personal analysis does not spare him from such involvement, but rather makes his feelings more available to him for the deep involvement which is so necessary.

First, the very length of time required for this therapy tends to foster a deep involvement on his part, such that the hours he has spent with the patient over the course of, say, six or eight or ten years, become deeply a part of all that the years have brought for him—the joys and sorrows, the triumphs and bereavements.

Secondly, the various forms of intense transference on the part of the schizophrenic individual tends forcibly to evoke complementary feeling-responses, comparably intense, in the therapist. Mabel Blake Cohen (1952) has made the extremely valuable observation, for psychoanalysis in general, that:

... it seems that the patient applies great pressure to the analyst in a variety of non-verbal ways to behave like the significant adults in the patient's earlier life. It is not merely a matter of the patient's seeing the analyst as like his father, but of his actually manipulating the relationship in such a way as to elicit the same kind of behaviour from the analyst. ...

It is not too much to say that, in response to the schizophrenic patient's transference, the

* From Chestnut Lodge, Rockville, Maryland, U.S.A. This study was supported by a grant from the Ford Foundation to the Chestnut Lodge Research Institute. Manuscript received 4 April 1961.

therapist not only *behaves like* the significant adults in the patient's childhood, but experiences most intimately, within himself, activated by the patient's transference, the very kind of intense and deeply conflictual feelings which were at work, however repressed, in those adults in the past, as well as experiencing, through the mechanisms of projection and introjection in the relationship between himself and the patient, the comparably intense and conflictual emotions which formed the seed-bed of psychosis in the child himself, years ago.

A third reason for the necessarily deep feeling-involvement on the part of the therapist is inherent in the nature of early ego-formation, the healthy reworking of which is so central to the therapy of schizophrenia. Spitz (1959), in his monograph concerning the early development of the ego, repeatedly emphasizes that emotion plays a leading role in the formation of what he describes as the 'organizers of the psyche' (which he defines as 'emergent, dominant centres of integration') during the first eighteen months of life. He says, for example, that:

... the road which leads to this integration of isolated functions is built by the infant's object relations, by experiences of an affective nature. Accordingly, the indicator of the organizer of the psyche will be of an affective nature; it is an affective behaviour which clearly precedes development in all other sectors of the personality by several months.

This brings us back to my other main topic, namely the phases comprising the over-all course of psychotherapy with the chronically schizophrenic person. Within recent years I have become growingly convinced that it is possible to delineate such phases amongst the complex, individualistic, and dynamic events of clinical work. One can take heart, in this difficult effort at conceptualization, from Freud's delineation of the successive phases of libidinal development in healthy maturation, from Erikson's (1956) portrayal of the process of identity formation as a gradual unfolding of

the personality through phase-specific psychosocial crises, and from Hartmann's (1956) statement, concerning the process of evolution of the reality principle in healthy development, that:

The impact of all stages of child development—the typical conflicts, the sequence of danger situations, and the ways they are dealt with—can be traced in this process.

The successive phases which in my experience best characterize the psychotherapy of chronic schizophrenia, with each of which the remainder of this paper will deal in turn, are (A) the 'out-of-contact' phase, (B) the phase of ambivalent symbiosis, (C) the phase of pre-ambivalent symbiosis, (D) the phase of resolution of the symbiosis, and (E) the late phase—that of establishment, and elaboration, of the newly won individuation through selective new identifications and repudiation of outmoded identifications.

The first three of these phases retrace, in reverse, the phases by which the schizophrenic illness was originally formed. To my way of thinking, the aetiological roots of schizophrenia are formed when the mother-infant symbiosis fails to resolve into individuation of mother and infant—or, still more harmfully, fails even to become at all firmly established—because of deep ambivalence on the part of the mother which hinders the integration-and-differentiation of the infant's and young child's ego. The child fails then to proceed through the normal developmental phases of symbiosis and subsequent individuation; instead, the core of his personality remains unformed, and ego-fragmentation and dedifferentiation become powerful, though deeply primitive, unconscious defences against the awareness of ambivalence in the object and in himself. Even in normal development, one becomes a separate person only by becoming able to face, and accept ownership of, one's ambivalent feelings of love and hate toward the other person. For the child who eventually goes on to schizophrenia, the ambivalence with which he had to cope in his relationship with

his mother was too great, and his ego-formation too greatly impeded, for him to be able to integrate his conflictual feeling-states into an individual identity.

My theoretical concepts have been fostered by Mahler's (1952) paper on autistic and symbiotic infantile psychoses and by Balint's (1953, 1955) writings concerning phenomena of early ego-formation which he encountered in the psychoanalysis of neurotic patients. In 1958, I ventured to express my conviction that a symbiotic relatedness between patient and therapist constitutes a necessary phase in the transference-evolution of successful therapy with either psychotic or neurotic patients, although it is particularly prominent and important in the former group (1958c). I have noticed with great interest, therefore, that Mahler & Furer (1960) emphasize that:

Our first therapeutic endeavour in both types of infantile psychosis [i.e. both autistic infantile psychosis and symbiotic infantile psychosis] is to engage the child in a 'corrective symbiotic experience'...

Loewald (1960a), too, reports that what I call a symbiotic relatedness occurs in the schizophrenic patient's transference to the therapist: in his way of phrasing it,

...If ego and objects are not clearly differentiated, if ego boundaries and object boundaries are not clearly established, the character of transference also is different, in as much as ego and objects are still largely merged....

It is now time to embark upon a description of the successive phases of therapy with the chronically schizophrenic adult patient.

(A) THE 'OUT-OF-CONTACT' PHASE

I do not term this the 'autistic phase', for the reason that the word 'autistic' has come to have a certain connotation, in psychodynamic theory, which I regard as invalid and therefore do not advocate. Specifically, the term 'autistic', as generally used, conjures up Freud's (1911) psychodynamic formulation of schizophrenia as involving withdrawal of libido from the outer world and its subsequent investment

in the self—as involving, in other words, a regression to narcissism. My own view is that there occurs instead, in schizophrenia, a regressive dedifferentiation toward an early level of ego-development which has its prototype in the experience of the young infant for whom inner and outer worlds have not yet become clearly distinguishable as such (Searles, 1961b). This is in line with the formulations of Werner (1940), and Loewald (1960a) follows the same reasoning in his previously mentioned paper.

To the degree that the patient is schizophrenic, this phase predominates during the early months, and in many instances the early years, of his therapy. Characteristic of this phase is the circumstance that his feelings are unavailable to himself and are not conveyed in his interpersonal relationships; hence the therapist experiences comparatively little in the way of feeling responses to the patient's behaviour, except for a sense of strangeness, of alienness, in reaction to the bizarre symptomatology into which the patient's feeling-potentialities have long ago become condensed—the hallucinations, the delusional and neologistic utterances, the stereotyped and manneristic non-verbal behaviour, and so on. It is seldom that the therapist feels that the patient even perceives him, sufficiently undistortedly so that the therapist can sense that he as a person in the here-and-now is being seen, or heard, or otherwise perceived, by the patient who much more often shows, instead, every evidence of being lost in a world of chaotically disturbed and distorted perceptions. Patient and therapist, so long as this phase endures, clearly have not yet entered into a deep feeling-relatedness with one another.

The feeling-orientation in the therapist which best serves a constructive approach to the patient and his bizarre symptomatology, and best facilitates the traversing and resolution of this phase of the therapy, is a calm, neutral, investigative orientation. By contrast, the inexperienced therapist is apt to approach the patient in a spirit of urgent need to relieve

the suffering of this deeply and tragically ill person. One is helped to relinquish such an attitude, which to the extent that it predominates renders constructive therapy impossible, by realizing a number of things about the patient. First, as Szalita-Pemow* helped me to see, the patient's individuality, his sense of personal identity, resides largely in his psychotic symptoms; thus the therapist is reacted to as threatening to rob him of his individuality, by 'curing' him of his illness. He has no conception of psychological health in our experience of this term; for him, 'getting well' is tantamount to a restoration of the state—the anxiety-ridden, unendurably boring, or what-not, state—which he experienced just before he originally became overwhelmed by the psychosis. Basically, 'getting well' is, for him, tantamount to loss of his individuality through return to symbiotic relatedness, toward which he is constantly being impelled by the inner drive which never ceases to pull him back toward the world of people. Also, for him, 'facing reality' is a very different thing from the therapist's being able to face the reality of *his* life; the reality of the patient's own life, which must eventually be confronted if he is ever to become well, is a reality overfull of tragedy and loss.

We need to realize, in the same vein, that the patient is not solely a broken, inert, victim of the hostility of persons in his past life. His hebephrenic apathy or his catatonic immobility, for example, represent for one thing an intensely active striving toward unconscious, regressive goals, as Greenson (1949, 1953) has helped to highlight in his papers on boredom and apathy in neurotic patients. The patient is, in other words, no inert vehicle which needs to be energized by the therapist; rather, an abundance of energy is locked up in him, pressing ceaselessly to be freed, and a hovering 'helpful' orientation on the part of the therapist would only get in the way. We must realize that the patient has made, and is continually making, a contribution to his own illness, how-

ever unwittingly and however obscure the nature of this contribution may long remain.

It is particularly when the therapist sees the dimensions of the patient's hostility, of his sadism, that he realizes that, on balance, the sufferer is doing what, on the over-all, he *wants* to do at the moment. When this understanding comes home to the therapist, he does not need to struggle to maintain some artificially neutral-screen façade, but comes to *feel* on the over-all neutral toward the patient whom he sees to be both loving and hateful, and whom, he increasingly realizes, he himself is capable of both loving and hating.

The therapist's hand can be strengthened, in effecting this change, by his identifying with his predecessors who have reported in the literature their achievement of such an attitude toward their work. Winnicott (1947), for example, points out how inevitably is hatred a component of the therapist's, as well as the normal mother's, feelings toward, respectively, the patient or the child. Knight (1940) describes his having found that, in the psychotherapy of paranoid patients, the use of such time-honoured techniques as reassurance, re-education, and tactfulness in dealing with the patient's homosexual wishes only causes him to become increasingly paranoid because, Knight saw, the patient has real hatred and this is what the anxiety is mainly about. Heimann (1955) finds it best not to try to convince the paranoid patient of one's good will, or to avoid coming to terms with his delusional material, and clearly sees the sadism involved in her patient's suffering. Hayward & Taylor (1956) find that 'When a patient is suffering, the decision as to whether to give comfort or to attack is often very difficult', and Hayward's recovered schizophrenic patient tells him, in retrospect, 'You should never have stood by and let me torture you by crucifying myself and making you watch my suffering. You should have forced me to come down or at least thrown rocks at me', and reminds him that 'People need practice in hating without guilt or fear, just as much as loving'.

The therapist, operating from this basic

* Personal communication (1952).

feeling-orientation, can meet usefully a wide variety of typical problem-situations; I can mention only a few. In response to the patient's manifestation of delusional thinking, he will be aware that, for the patient, the delusions represent years of arduous and subjectively constructive thought, and are therefore most deeply cherished. He will not forget that obscured in them is an indeed indispensable nucleus of reality-perception. He will not become caught up in either disagreeing or agreeing with the delusional view, but will try to help the patient explore the feelings which this delusional world-view causes him to feel—the dismay, the shock, the despair, and fear, and so on. Not only here, but in general, free from any absorbingly urgent need of his own to 'cure' the patient, he will remain attentive to what the *patient* is experiencing. He will couch his remarks in terms of the patient's own presumed point of view, and when the patient is able to express a feeling—whether of fear or loneliness or anger or what-not—the therapist will usually content himself with simply acknowledging the feeling and encouraging its further elaboration, rather than rushing verbosely to somehow relieve the patient of it. Likewise, when a patient is having vigorously to disavow any feeling about a clearly affect-laden matter, the therapist will remain in tune with the patient's own feeling experience, by remarking, 'I gather you don't find yourself having any particular feeling about this',—or, better, will make no mention of feelings—rather than trying to overcome the unconscious denial by asserting; 'But surely this *must* make you very angry (or hurt, or what-not)'. Similarly, in responding to the expressions of an archaic, harsh superego in the patient, rather than setting himself up as the spokesman, the personification, of the repressed id-impulses, he will realize that it is in the superego that the patient's conscious self—his personal identity—mainly resides; thus he will seldom urge the patient to recognize sexual or aggressive feelings within, and will more often acknowledge how strong a sense of protest or outrage the patient feels upon perceiving these in others.

To the extent that the therapist is free from a compulsion to rescue the suffering patient, he can remain sufficiently extricated from that suffering to be able to note significant sequences in the appearance of such symptoms as hallucinations, verbalized delusions, and so forth, and thus be in a position to be genuinely helpful. Even when on an auto ride with a patient, or grappling with the latter's physical assault, the therapist may on occasion be able to allow himself sufficient detachment to help the patient to link up this immediate experience, clarifyingly, with forgotten situations from earlier life; such 'action interpretations' may be especially important to the patient whose memory, and whose capacity for abstract thinking, are severely impaired.

In working with the patient during weeks or months of silence on the latter's part, he will not, out of a compulsion to help the tragic victim of schizophrenia, rack his brain with diligent therapeutic efforts focused upon the patient, who is already afflicted with overwhelming intrapsychic pressures. Rather, the therapist will feel free to let his thoughts roam where they will, leaf through magazines, do some serious reading of current interest to him, and otherwise see to his own personal comfort and freedom from anxiety. This may at times involve periodic letting off of steam at the inarticulate patient; but such blasts do, in my experience, no harm to the patient and help one to become again, for a relatively long period, genuinely accepting of this difficult situation. Thus one places on the over-all a minimum of pressure upon the patient who is already paralyzed with pressure, and keeps oneself in a comparatively unanxious and receptive state which, better than anything else, helps eventually to relieve the patient's anxiety and unlock his tongue. Sooner or later, like a bright dawn pushing back a long night, the patient will put his rusty vocalization capacities to work in venting reproach, contempt, and fury upon the therapist for doing, as the former sees it, nothing to help him.

In general, while aware that the parents responded to the patient in certain ways—such as

by condemnation, reproach, contempt, or what-not—which promoted illness in the child, the therapist will refuse to tie his own hands with any self-imposed injunction to make his own behaviour always an antidote for such early trauma, and never to engage in such responses himself. He knows that there will be times when such responses are the only realistic ones to make to a given piece of behaviour on the patient's part, and he rests assured that if the patient were never able to find *anything* of the latter's mother or father in the therapist, the transference-reliving, and eventual resolution, of the schizophrenic illness would be impossible. One could postulate with some confidence that a person whose intrafamilial relationships had been so warped as to lead to schizophrenia would quite simply be at a loss to know how to relate, would have insufficient tools from past experience for relating, to a hypothetically ideally loving-and-mature therapist.

The therapist learns to take fewer and fewer things for granted in this work, learns to question more and more of his long-held assumptions and discard many of them. He learns that one does not set a ceiling upon any human being's potential growth. He finds recurrent delight in the creative spontaneity with which the schizophrenic patient pierces the sober and constricting wrappings of our culture's conventions, and he discovers that humour is present in this work in rich abundance, leavening the genuine tragedy and helping to make it supportable. While developing a deep confidence in his intuitive ability, when working with the severely fragmented or de-differentiated patient he will not jump too quickly to attempt communicational 'closure' (in the Gestalt sense), but will leave it in the patient's hands to do, no matter how slowly and painfully, the parts of the communicational work which only the latter can do. Meanwhile, he will not need to shield himself, through the maintenance of an urgently and actively 'helpful' or 'rescuing' attitude, from feeling at a deep level the impact of the fragmented and dedifferentiated world, with its

attendant feelings, in which the patient exists. The unfolding of such feeling-experiences, which will be elaborated in my portrayal of the next phase of the therapy, the 'urgently helpful' therapist-attitude is unconsciously designed to avert, comparable to the defensive function, in the patient, of the latter's schizophrenic delusions.

I hope to have made it sufficiently clear that, in describing a basically neutral feeling-orientation toward the patient, I am not thereby recommending that the therapist should assume, and hold to, any rigid professional role of 'the psychiatrist'. My experience of this coincides with that indicated by a number of workers in this field. Robert A. Cohen (1947) reports, concerning his therapy of a paranoid schizophrenic woman, 'the patient's unfavourable reception of any remark which smacked of the usual psychiatric jargon', and learned to avoid becoming so interested in the *content* of her delusions as to lose track of their *feeling-implications* for the patient. Lidz & Lidz (1952) point out that: 'More paranoid patients, in particular, can participate in treatment but cannot be treated in the sense of having another person control or manage them'. Bullard (1960) offers to the paranoid individual 'not interpretations but, rather, hypotheses for the patient to consider as possibly shedding some light on the problems he is exploring'. The basic orientation I recommend is well described in Loewald's (1960a) remarks about psychoanalytic work,

... Through all the transference distortions the patient reveals rudiments at least of that core (of himself and 'objects') which has been distorted. It is this core, rudimentary and vague as it may be, to which the analyst has reference... and not some abstract concept of reality or normality, if he is to reach the patient. If the analyst keeps his central focus on this emerging core he avoids moulding the patient in the analyst's own image or imposing on the patient his own concept of what the patient should become. It requires an objectivity and neutrality the essence of which is love and respect for the individual and for individual development...

(B) THE PHASE OF AMBIVALENT SYMBIOSIS

To the extent that the therapist's basic orientation toward the patient is a neutrally investigative one, one free from a compulsive need to help and to love the patient, but one open, rather, to the sensing of hateful as well as loving feeling-tones in the therapeutic relationship, he comes progressively to detect the intense ambivalence which has been locked within the patient's psychotic symptomatology. He detects this, before the patient himself has become able to experience and verbally express such ambivalence, through the awareness of sudden fluctuations of his own feelings in reaction to the patient's verbal and non-verbal communications. He finds his feelings toward the patient switching unexpectedly from, for example, tenderness to contempt, or from fury to grief, or what-not. He finds himself experiencing, on occasion, feeling-states which are quite ineffable and foreign to his memory and which, despite whatever roots in his own preverbal childhood, can usefully be regarded as samples of the feeling-states at work in the patient himself, though more probably than not outside the latter's awareness as yet.

The prolonged silences, or obscurity of verbal communication, or both, which characterize the work with the chronic schizophrenic patient have served to foster a progressive weakening of ego-boundaries between patient and therapist. That is, in this situation of clouded communication, projection and introjection on the part of each participant is facilitated to an extent which is seldom if ever seen in an analyst's work with a neurotic patient, for in the latter instance the frequent and clear verbalizations, from each participant, tend to keep *relatively* clearly highlighted the ego-boundaries between the two participants. Thus there develops a generous reality-basis for the symbiotic transference which the schizophrenic patient tends powerfully, in any case, to form with his therapist. The therapist's own ego-boundaries are weakened not only in reaction to the prolonged silences and in reciprocity to

the patient's transference, as indicated in the above-mentioned comment by Mabel Blake Cohen, but also for the reason that regression toward symbiotic relatedness tends to occur in the therapist himself as an unconscious defence against the intense and deeply ambivalent feelings—of helplessness, fury, loathing, tenderness, grief, and so on—evoked by his relationship with the schizophrenic patient, long prior to that relationship's having become strong enough, and well-defined enough, to permit his recognition of these feelings, and any full-scale expression of them, toward the patient.

As I have described in earlier papers (1958 *c*, 1959 *a*, *b*), the therapist at times will find himself in the extremely uncomfortable state of experiencing two quite different, and subjectively unrelated, feeling-attitudes toward the patient simultaneously. Particularly in instances in which one or another parent was psychotic, the patient tends to form such a subjectively ego-splitting kind of transference toward the parent-surrogate therapist. The relatedness between patient and therapist comes, sometimes for several months, to bear many of the earmarks of a mutual effort to drive one another crazy (1959 *a*). I have described elsewhere (1958 *a*) some of the manifestations of the patient's vulnerability, during this phase, to the disturbing impact of the therapist's unconscious processes.

More and more the therapist comes to feel enmeshed, as it were, in the patient's own ego-fragmentation and dedifferentiation. The therapy has a sticky feel about it; the therapist feels restrained from any decisive actions, incisive comments, or even clear-cut and unambivalent feelings toward the patient. His resentment, rage and hatred toward the latter are tormentingly guilt-provoking in nature; and his tender and loving feelings are hardly less burdensome and guilt-provoking. He feels that he does not truly love the patient, but has only an ugly lust which will not stand the light of day; and when he does feel that his love is more of a parent-to-child order, his love feels guiltily possessive. He is painfully

aware of being like a jealous Pygmalion concerning this Galatea with whom is he at once blessed and afflicted: he looks to his colleagues for succour, but deeply resents any participation from a third person—psychiatric administrator, therapeutic supervisor, nurse, or whomever—as an intrusion into his own private domain. One other simple earmark of this phase of ambivalent symbiosis is the circumstance that the relationship with this patient has assumed an absorbing, unparallelled *importance* in the therapist's life, an importance which not only jars with such relationships with other staff-members as impinge upon the situation, but which he experiences also as a competitive threat to his most personal and cherished non-professional relationships.

At its fullest intensity, this phase is experienced by the therapist as a threat to his whole psychological existence. He becomes deeply troubled lest this relationship is finally bringing to light a basically and ineradicably malignant orientation toward his fellow human beings. He feels equivalent to the illness which is afflicting the patient; he is unable to distinguish between that illness and himself. This is not sheer imagination on his part, for the patient is meanwhile persistently expressing, in manifold ways, a conviction that the therapist constitutes, indeed, the affliction which threatens to destroy him and with which he, the patient, is locked in a life-and-death struggle. In my theoretical view, the therapist is now experiencing the fullest intensity of the patient's transference to him as the Bad Mother.

The patient's own ego-boundaries may be so unclear that it may be impossible to know whether, when he speaks, he is uttering thoughts which are subjectively his 'own', or rather giving voice to what he assumes the therapist to be thinking but not expressing. The therapist will often find it similarly impossible to know whether a predominant feeling-tone of anger, or grief, or what-not is welling primarily from the patient or from within himself.

Murderous feelings arising within the therapist tend particularly, in contrast to more

readily acceptable feelings, to become projected upon the patient, whose own oftentimes prominent assaultive tendencies offer a ready reality-basis for such projections. The therapist in these circumstances is prone, for various reasons some of which are quite obvious, to the development of intense murderous feelings. These result from the intense frustration of his therapeutic endeavours, the threat to his individuality arising from the symbiotic relatedness with the patient, and his residua of infantile omnipotence brought to bay during the mutual regression which this symbiosis involves, such that the therapeutic relatedness often takes the form of a raging struggle between two gods. There supervenes, thus, all the murderousness of the thwarted infant not only in the patient but in himself also.

Uncomfortable though it is for the therapist to feel afraid of the murderous patient, it is still harder for him to realize the full extent of his own murderousness toward the patient, and to see that the latter is unaware of feeling murderous and is experiencing, instead, intense fear of the therapist who is viewed as murderously insane. It is more acceptable to the therapist's superego to feel intimidated than intimidating, and the realization that the patient is deathly afraid of one tends, at least initially, to weaken one's own feeling of control over one's rage.

I have reported elsewhere (1958*a*) a dream which I had during the course of my work with a hebephrenic man whom I had been viewing, for some months, as being a dangerous, uncontrollable person. In the dream, during a desperate struggle between us he got his hands on a knife-like letter-opener. But then *he* took *me* into custody and at the end of the dream he was functioning as a kind of sheriff's deputy, marching me out to turn me over to the authorities. This dream was one of the developments which helped me to become aware of massive, previously-repressed rage in myself which I had been projecting upon the patient. A colleague reported to me in a supervisory hour, two weeks ago, the uneasy feeling that he and the patient were presently in a state of ostensible calm which was really the calm, he sensed,

of the eye of a hurricane; he felt that there was some as-yet-undefined fury in the patient which was looming somewhere. But in last week's supervisory session he reported various intimations of a previously unsuspected quantity of rage in himself, such that he said, 'I'm not sure now whether the hurricane is in her, or in me'.

More often than not the therapist is, unlike the colleague just mentioned, unaware that a state of symbiosis is developing, or has long been established, between the patient and himself. This state of affairs is easier to detect in one's colleagues than in oneself. When one becomes alert to the significance of this phase of the therapy with the schizophrenic person, one is struck by how frequently one hears therapists make, in supervisory sessions or in staff-presentations, such comments as 'There's been a lot of anger this past week', without specifying in *whom*; or, likewise, 'There's a manicky mood around—there's a lot of giggling'; or, 'There is a very strong dependency there', without specifying *where*. The therapist may make repeated slips of the tongue concerning the sexual identity of the patient—a response not only to the deep-seated sexual confusion in the patient which has now come to light, but a function also of the therapist's lack of differentiation between his own sex and that of the patient. He may say, 'I started seeing her in [a cold, wet sheet] pack', in such an ambiguous tone as to make one wonder momentarily whether he means that she was in pack, or he was in pack, or both were in packs. On rare occasions one may hear: 'The first period when he was my therapist was—I mean, the first period when I was his therapist was....' One becomes alert to such clues in one's own presentations also.

The dissolution of ego-boundaries between patient and therapist is only a major aspect of a more general dedifferentiation-and-disintegration of ego-functions which occurs in both participants (although to a much lesser, and therefore more subtle, degree in the therapist, of course, than in the patient) as the symbiotic relatedness develops. Thus the therapist, los-

ing temporarily his ability fully to differentiate between fantasy and reality, may react to various of his sexual fantasies about the patient with as much guilt as though they represented consummation in behavioural reality, and may feel jealous of the hallucinatory figures with which the patient is immersed in a seemingly lively and intimate interaction, as though these hallucinatory figures were to be compared on a par with himself (Searles, 1961 c). On occasion, too, during this phase, childhood scenes have welled up in my memory with an almost overpoweringly tangible reality. One feels from time to time, too, the impact of some previously unglimped fragment of the patient's past, conveyed to one now by him in ways that are largely non-verbal and hard to objectify.

Before this phase of ambivalent symbiosis can give place to the succeeding one in the therapeutic sequence, the relationship between patient and therapist must gradually grow, through the resolution of innumerable and increasingly severe tests of the kind mentioned above, sufficiently strong so that the therapist can endure the fullest intensity of the patient's hostility, focused directly upon him. In contrast to the warnings given by Sullivan (1956), Hill (1955), and many other writers, to the effect that such a development means that the therapy has foundered irretrievably, I have come to see this, both in my own work and in that of my colleagues, as an utterly essential therapeutic development. The patient can never become deeply a whole person unless he has this chance to, in Hoedemaker's (1955) way of describing it, identify with the therapist who survives the fullest intensity of this kind of attack to which the patient was exposed in childhood and from which he, the patient, had to flee into psychosis. And complementarily, I have found that it is an equally essential part of this phase that the therapist finds himself gradually coming, step by step, to express openly—even though not as often as he feels it within—the very fullest intensity of his own hatred, condemnation, and contempt toward the patient, expressing these in ways which are unconsciously patterned after those ways by which

the parents expressed their destructively negative feelings toward the patient as a child; the therapist's responses are so moulded, in powerful degree, by the patient's transference, and it is thus that the patient is at last able to cope successfully with, symbolically, the parents' destructiveness, recapitulated in the therapist's side of the transference relatedness. The deep reassurance which therapist as well as patient derive from finding repeatedly that each can survive the other's, and his own, baring of hatred at its fullest means that the foundation for the next therapeutic phase, that of full—or, genetically speaking, preambivalent—symbiosis has now become established.

(C) THE PHASE OF FULL, OR
PREAMBIVALENT, SYMBIOSIS

This phase, which is ushered in gradually and—as in the instances of the other phases I am describing—with unceasing fluctuations toward both earlier and later phases, most often makes its presence known in terms of the therapist's finding, to his surprise, that his largely silent hours with the patient are no longer a source predominantly of conflict and anguish to him, but rather a source mainly of pleasurable contentment, contentment which his superego at first reacts against as being reprehensible in view of the still formidable degree of illness in the patient after the passage of these many months of treatment. Or the therapist may discover, in the course of work with a largely verbal patient, that their verbal encounters have somewhere along the way lost their disturbing, anxiety-provoking and hurtful quality, and are now predominantly, though largely deniedly, cherished by both himself and the patient.

The therapist comes more and more unconflictedly to accept, now, both the feelings of a Good Mother who has a godlike importance to the little infant in the patient, as well as his own equally infantile-dependent feelings toward the patient as a similar Good Mother; the therapeutic relatedness, having progressed to the preambivalent mother–infant symbiosis,

oscillates between the therapist's being now in the one position, now in the other, toward the patient.

I cannot overemphasize the extent to which it is the little child in each participant upon whom mutual trust must eventually be placed, for therapy to succeed; in the Biblical phrase, '...and a little child shall lead them'.* Psychotherapy with the schizophrenic patient tends naturally to involve the therapist's feelings at the level of his own early childhood experiences. He powerfully responds to the patient as being an omnipotent mother, both because the latter's history of prolonged symbiotic relatedness with the mother has fostered strongly maternal qualities in the patient, and also because the present deeply undifferentiated state of the patient's ego gives the therapist the impression of unlimited potentialities for the therapist's own gratification.

One's love for the patient is now experienced as boundless and unthreatening, no longer a threat to, for example, one's relationship with one's wife and children, but rather a confirmation of one's ability to love whomever. The sexual components of the love are no longer experienced as predominant, but submerged in a kind of boundless, fundamentally maternal, *caring for* the patient. This love, experienced toward the patient who is a member of one's own sex, is no longer experienced, as it was previously, as being any threat to one's sexual identity. Such hateful feelings as do from time to time arise become progressively guilt-free and actively enjoyable, on the over-all much subordinate in power and frequency to loving feelings, and increasingly rapidly revealed as defensive against the intensely tender love which underlies them. One comes to see that, at this level of dedifferentiation, 'love' and 'hate' are one, and that any intense and overt relatedness is, in effect, love. One of my patients, during such a phase, expressed her realization that 'There's a very thin line between love and hate'.

The patient's formerly archaically-harsh

* Isaiah xi. 6.

superego is seen progressively, now, as no longer a giant foreign body in the patient-therapist relatedness, but rather as the vehicle for the patient's expression of his most deeply denied, but by the same token, most intense and intimate, love for the therapist-mother. Comparably, the therapist finds that his own vestiges of infantile omnipotence, fanned to flame by the 'struggle-between-two-gods' nature of the ambivalent phase of symbiosis, give way to a realization, and deep acceptance, of his inability to 'cure' the patient through any exercise of rageful, godlike authority—his inability, that is, to bend the patient to his will by 'curing' him. There emerges in him then a feeling-orientation which, achieving what I have experienced as a 'gentle victory' over the domineering god-infant in oneself, is felt, for all its quiet gentleness, to be awesome in its power: a loving acceptance of the immediate relatedness with the patient, founded upon the knowledge that one's now full and unswerving dedication to his recovery, mingled with the patient's own increasingly liberated striving toward health, comprise together a current which is carrying the therapeutic process forward. Out of this whole-hearted commitment of feeling by both patient and therapist, we understand the accuracy of the comment made by Bak (1958), that to the degree that the adult person is truly mature, there is in him no realm of the super-ego, demarcated as such within the over-all functioning of the personality; and of Anna Freud's (1946) observation that '...our picture of the super-ego always tends to become hazy when harmonious relations exist between it and the ego. We then say that the two coincide....'

The therapist experiences not only the above-mentioned sense of whole-hearted commitment to the therapeutic relationship, at a depth which, he now realizes, despite all his previous expenditures of effort and feeling, he never felt before; he responds to the patient, during the therapeutic session, as being of boundless personal importance to him, and becomes progressively unafraid to acknowledge this on occasions when the patient needs

such acknowledgement. It is not too much to say that the therapist feels the patient as necessary, even, to complete himself; temporarily and acknowledgedly, that is, he feels toward the patient that which the 'schizophrenogenic mother' was not strong enough either to acknowledge or to relinquish: the need for the patient to complete her own personality. For years we have been accustomed to totally damning this phenomenon as wholly destructive, and productive of schizophrenia; we need to realize that the core of any human being's self esteem is traceable to the healthy infant's experience that he is indeed needed to complete the psychological wholeness of the mothering person; it is there, I have come to believe, that the core of the *raison d'être*, for each of us, is to be found.

By the same token, the therapist should not be ashamed to receive from the patient such help in personal integration as the patient is able to provide; in this regard I fully concur with Whitaker & Malone (1953). The healthy child's self esteem is strengthened by the experience that, just as his mother needed him to complete herself in his infancy, she now finds him deeply helpful in fostering her personal integration, her maturing. We should be able to have the courage to see, and acknowledge, these aspects of the symbiotic core of therapeutic interaction, when we see that, as long ago as 1923, Groddeck (1923) had the courage to describe how, in his treatment of one of his patients:

... Her childlike attitude towards me—indeed, as I understood later, it was that of a child of three—compelled me to assume the mother's role. Certain slumbering mother-virtues were awakened in me by the patient, and these directed my procedure.... And now I was confronted by the strange fact that I was not treating the patient, but that the patient was treating me; or, to translate it into my own language, the It of this fellow-being tried so to transform my It, did in fact so transform it, that it came to be useful for its purpose.... Even to get this amount of insight was difficult, for you will understand that it absolutely reversed my position in regard to a patient. It was no longer important to give him instructions, to

prescribe for him what I considered right, but to change in such a way that he could use me.

The therapist, at moments when he is in the position of the mother in the mother-infant symbiosis, may have vivid fantasies of giving suck to the patient as a happily nursing infant; Warkentin & Taylor (Whitaker, 1958) have described the physical accompaniments of such fantasies, and I, too, have experienced these in my work with a number of patients. It is equally important that the therapist become able to accept his nursing-infant fantasies toward the patient, whether female or male, for otherwise the patient cannot learn to deeply accept his own desires to nurture—the primeval basis for all givingness. I find it impressive, in this connexion, that Sechehay (1951), Eissler (1951), Schwing (1954), Hayward & Taylor (1956), Whitaker & Malone (1953) and many other therapists are in agreement concerning 'the absolute necessity for a happy infantile experience with a good mother before the patient can begin to grow toward adult reality' (Hayward & Taylor, 1956), and it is of additional interest that the recovered schizophrenic patient reported by Hayward & Taylor, who gave a detailed account of her therapy as she saw it in retrospect, 'stressed that the happy nursing experience was the most important single part of her therapy'. I am trying here to describe something of how this particular phase of the therapy, this 'happy infantile experience with a good mother' phase, actually manifests itself, particularly in terms of the therapist's experiences during it.

A mutual spirit of childlike playfulness is another prominent characteristic of this phase. Because the ambivalent stage of the symbiotic transference-relatedness has been successfully traversed and the stratum of preambivalent lovingness attained, the lack of structure, the lack of rigidly defined boundaries between patient and therapist, or between such intrapsychic realms as those of remembered 'reality' and those of creative fantasy, or those of concrete imagery and those of metaphorical or allegorical or otherwise highly figurative imagery, is experienced no longer as a

threatening kind of dedifferentiation, but rather as giving both participants the unfettered opportunity to playfully trade places with one another (and even, in one instance in my experience, to imaginatively trade various body-parts with one another), and to playfully gambol about all these various realms of psychological experience in a mix-up which is oftentimes thoroughly merry to both of them. One finds something which one had never thought possible: confusion itself, usually regarded in psychiatry as so tragically destructive to the patient and threatening to his therapist, can be actively pleasurable in an atmosphere where a sufficient degree of mutual trust has been reached so that, where hate for all practical purposes does not exist, confusion is no longer tantamount to vulnerability, and ego-structure need not be thrown up as a poorly erected bulwark against external threat, but can form at its own pace as, primarily, a growing organization for the expression of increasingly complex inner potentialities and, therefore, needs.

It is appropriate at this juncture to note the impact upon the over-all hospital environment of the foregoing phase in the psychotherapeutic relationship, namely the phase of ambivalent symbiosis, and of this phase of full or preambivalent symbiosis. In the former phase the patient-therapist relationship tends to foster incessant and severe splits among the group of patients-and-personnel on the ward, pervading, at times, the social structure of the whole hospital. By the same token, the deep ambivalence in the patient, as well as the not inconsiderable ambivalence roused responsively in the therapist in the course of the therapy, tend to make their relatedness the ready instrument for the expression of already existing, latent disagreements rife in the social environment surrounding them; thus, of the ambivalence which permeates this larger social environment, their therapeutic relationship is at once cause and victim. Such ambivalently symbiotic phenomena in the larger social structure of the hospital have been well described by Stanton & Schwartz

(1954), Main (1957), Perry & Shea (1957) and others; I have reported my own experience with, and interpretations of, such phenomena (1959b).

Many a therapeutic relationship miscarries and the therapist and patient, unable to face and resolve the intense, mutual hatred which is evoked by the symbiotic phase of the psychotherapy, repress this hatred, project it on to various figures in the surrounding social matrix of the hospital, and become locked into a relatedness in which they both share the fantasy of being lovingly at one. But this is not the truly preambivalent phase of the transference-symbiosis which they are experiencing; rather it is, as those responsible for the long-run management of the hospital are painfully and irritatedly aware, predominantly a *folie-à-deux* between patient and therapist, in which symbiosis is functioning mainly as a defence against the recognition of mutual hatred. This development is so common that I have come reluctantly to conclude that there is no sure criterion by which one can know, for long periods of time, whether one is involved in a genuinely preambivalent symbiosis with the patient, or rather in the predominantly paranoid symbiosis which is a defence against hatred; there is no kind of litmus paper which will definitely tell us, and we must remain open-minded to the ever-present possibility that, for example, a basically constructive, subjectively preambivalent symbiosis will be misused unconsciously from time to time, by both participants, to keep out of awareness increments of particularly intense hostility.

Even in those treatment-relationships where a healthy, preambivalent symbiosis is in full sway, it is not always easy for the social environment to take. The therapeutic relationship even here needs a kind of delicate handling, much as a pregnant woman needs special care from her environment even when the pregnancy is progressing well. For example, neither therapist nor patient is yet ready for any third person to come upon the scene as a consistently valued, and openly-acknowledged, contributor to their mutual therapeutic work.

Further, the subjectively irresponsible playfulness and contentment, so genuinely healing in itself and so central an ingredient of the preambivalent symbiosis, nonetheless strains the faith and patience of others on the hospital staff who have little or no opportunity to participate in the favourable developments I have been describing, and who are aware mainly of such conspicuous factors as the patient's already-long hospitalization, his persisting manifestation of various chronic symptoms in his daily life on the ward, and perhaps, the intimations from the family that this hospitalization cannot be underwritten indefinitely.

'They were going around on a merry-go-round—no, not on a merry-go-round, because that implies movement', snorted a supervisor at a recent staff conference, concerning the therapeutic relationship between a hebephrenic woman and her therapist who were, from my view, in the midst of the phase of preambivalent symbiosis at a time when, for extraneous reasons, the therapist had had to leave the Lodge to return to his distant home-country. 'Going around on a merry-go-round' is a beautiful way of describing the kind of therapeutic interaction in which it is so important for the patient and therapist to become able freely to participate, but which is so difficult for the hospital organization to permit. I myself, who 'know' these things as well as I know anything about the therapy of schizophrenia, feel, when in the role of supervisor hearing from a therapist concerning his work during such a phase, unenjoyably aware of being an 'outsider' to the so-intimate two-person relatedness I am hearing about at second hand, and must work against my tendency to express envious resentment to the therapist through admonitions and reproaches that he should buckle down to the business of psychotherapy with the patient—the worst possible supervisory response at this phase of the therapy. By contrast, the sheepish therapist obtains invaluable help from his supervisor's realization that what is going on in therapy is the very essence of what is good for

the patient, confirming the therapist's own courage to go on doing this in the face of the reproaches of his own all-too-conscientious super-ego.

(D) THE PHASE OF RESOLUTION OF
THE SYMBIOSIS

The complex individualistic needs of the two participants, and thus their respective strivings-for-individuality, will not tolerate indefinitely the perpetuation of the therapeutic symbiosis. The basic function of this symbiosis is, after all—despite the intense regressive gratification which it holds in itself—a maturational one: it provides the patient, and to a not insignificant degree the therapist also, with a basis for renewed, and healthier, development of individuality. Thus, after a period extending from, as best I have been able to determine, a few months to one or two years, the dynamic equilibrium of the therapeutic relatedness shifts increasingly toward resolution of the symbiotic phase. The initiative for this shift may be manifested first by either patient or therapist, and it is my impression that the resolution-process—that is to say, the process of both participants' coming to be subjectively, and to function as, individual persons, rather than partners in symbiosis—proceeds by turns, with now the one, and now the other, showing the greater push toward emancipation. I shall describe first the therapist's experiences when the initiative is in his hands, and then his experiences in reaction to the patient's showing such initiative.

One of the therapist's typical feelings, in the former instance, is a quiet, subjectively unaccountable, but deeply memorable sense of apartness from the patient, a feeling-realization that the patient is outside oneself—a realization that the patient is a person 'over there', a person afflicted with a schizophrenic illness which is, likewise, 'over there' in the patient. One facet of the therapist's realization is, then, that he—the therapist—is not the patient's illness. This shift in feeling-orientation is at times experienced, also, as a sensation of now

being, at long last, 'out of love with' the patient—a feeling always, for me, tinged with some guilt in those instances in which the patient is still showing much need for persisting symbiosis with me beyond the time when I have now 'outgrown' it.

On other occasions, the therapist experiences a resolution of the symbiosis, or at least a step in this resolution-process, not in this quiet and subjectively inscrutable way, but rather with a sudden sense of *outrage*. The very word '*outrage*' is significant, and the feeling it designates is qualitatively different from annoyance, anger, or even rage. He feels outrage at this or that chronic regressive symptom in the patient, or outrage at the latter's whole regressive symptomatology, and always outrage at the unreasonableness of the demands which the patient has been making upon him, these many months or years. He sees the enormity of these demands which the patient has been placing, through his illness, upon him and other persons, and sees clearly the folly of acquiescing further to these regressive demands. He is suddenly and vigorously determined to give no more of his long-time dedication, now seen as misplaced dedication, to the gratification of these demands, which he formerly saw as infant-needs which it would be unthinkable to brush aside.

The therapist sees now, by the same token, the full interpersonal offensiveness of the patient's defence-mechanisms, whereas he possessed heretofore a high degree of tolerance for such offensiveness in his patient and maintained a devoted effort to see, and empathize with, the anxiety, the hurt, the loneliness, and so on, against which the patient has been unconsciously protecting himself through the use of these defence-mechanisms. In my work with, for example, one paranoid schizophrenic man who chronically manifested intense scorn and sarcasm in his dealings with other persons including myself, for nearly two years I had experienced increasing forbearance toward, and sympathy with him as I saw more and more clearly the feelings of hurt, disappointment, and so on which the scorn and

sarcasm was serving to maintain under repression. But then, with the advent of the resolution-of-symbiosis phase, it forcibly dawned upon me how genuinely obnoxious, to me as well as to others, he was being with his scorn and sarcasm, the defensive function of these notwithstanding.

In other words, one now holds the patient highly responsible for his symptoms. One now leaves in his hands the choice as to whether he wants to spend the remainder of his life in a mental hospital, or whether he wants, instead, to become well. In every instance that I can recall from my own experience, I have found occasion to express this newly won attitude to the patient himself, emphasizing that it is all the same to me. These are no mere words, but the expression of a deep and genuine feeling-orientation. One cares not, now, how callous this may sound, nor even whether the patient will respond to it with suicide or incurable psychotic disintegration; and one feels and says this while casting one's own professional status, too, into the gamble, not to mention the potential feelings of lasting remorse to which one might be subject in case one's communication had such an irremediably destructive effect upon the patient. Thus, in effect, one braves the threat of destruction both to the patient and to oneself, in taking it into one's hands to declare one's individuality, come what may.

It may well be that individuation—the resolution of symbiosis—innately contains, even in the healthy maturation of the young child, this element of going ahead in the face of such a life-and-death threat. Incidentally, if this is a life-and-death threat. Incidentally, if this is true, we have here the primordial determinant of democracy's tenet that it is better to brave death than to live as any other than a politically free individual.

Part of this new attitude on the therapist's part is a readiness to let the patient 'stew in his own juice', in contrast to his having often found himself, previously, vicariously expressing the patient's feelings in the symbiosis which then obtained. Likewise, he feels a new freedom to express his own individual thoughts and

feelings to the patient as an individual—or as, at any rate, one whose nascent individuality is increasingly in evidence—without being hampered by concerns as to whether he is being inconsistent toward the latter, or is treating the latter unfairly in comparison with his other patients—a not unimportant aspect of the work, when one has two or three patients on the same hospital ward.

The therapist feels a clear realization, with all this, of the fact that he himself is no longer indispensable to the patient; he realizes, that is, that he himself is not the only conceivable therapist who can help the patient complete the journey to health. He can look about him and see various colleagues who, he can readily imagine, would fill this capacity as well as, or possibly better than, he can fill it. He feels now a lively appreciation of, a genuine welcoming of, the invaluable contributions to the patient's recovery which have been made, are being made, and will continue to be made, by nursing personnel, relatives, various of the other patients on the ward, and so on. This is in marked contrast to the therapist's feeling earlier in the work, a grandiose feeling but, I think, a feeling quite essential to the development and maintenance of the therapeutic symbiosis, of being a God the Creator in the therapeutic situation, of being the only conceivable Pygmalion for this Galatea; that feeling was, after all, of a piece with the mother's sensing of her own god-like indispensability to her so-needful infant. The therapist's subsequent realization, now, that these others are helping in major ways to meet the patient's needs, comes predominantly as a deeply reassuring one; but it has, obviously, affective ingredients of deflation and loss.

One sees the loss-aspect of the therapist's experience more clearly at those junctures when the patient, rather than the therapist, is manifestly showing a determination to grow free of the symbiosis. One of my most frequent experiences as a supervisor is that of helping a therapist to explore his feelings of dissatisfaction and despair about a current therapeutic relatedness in which, he is consciously

convinced, the schizophrenic patient is showing discouraging stasis, but in which the patient is actually evidencing, as shown by various subtle clues, all too many indications of a growing, though still somewhat submerged, determination to slough off the symbiosis in which the therapist has a far deeper feeling-investment than he cares to acknowledge to himself. The therapist paradoxically finds himself despairing, for example, just at the time when the patient has actually been opening up unprecedentedly deep areas for investigation—areas of fondness and dependency toward the therapist, areas of confusion or other disturbed subjective experience, and so on. One unconsciously employs, as therapist, the same defence-mechanisms against recognising the beginning resolution of the symbiotic phase as one employed, earlier, against the recognition that this phase of symbiosis was becoming more and more deeply established—namely the defence-mechanisms of denial and reaction-formation: the denial of how well the work is actually proceeding, denial of how much the patient means to oneself, denial of how deeply cherished are the gratifications which one is obtaining or has been obtaining, denial of how deep is the sense of loss which further change will bring; and reaction-formation feelings of impatience and dissatisfaction, as part of one's struggle to maintain under repression feelings of contentment, satisfaction, and accomplishment.

I think it correct to say that the therapist, no matter how mature or experienced, inevitably reacts somewhat against any move on the patient's part into a new area of feeling, a new area of psychotherapeutic investigation. This is partly for the reason, as I have mentioned elsewhere (1961 *a*), that the patient's sense of identity is so deeply invested in the old way of experiencing things, the old and familiar way of relating to the therapist, that he, the patient, would experience a major threat to his sense of identity if the therapist were somehow able to welcome with unambivalently open arms this move into a new area of experiencing and interpersonal relating. But it is partly for the

reason, too, that the therapist has a more or less deeply imbedded emotional investment in the familiar, more predominantly symbiotic mode of relatedness with the patient, and hence reacts against the threat of personal loss with which the patient's new growth as an individual confronts him.

I have had the experience of finding that a hebephrenic woman, with whom I had been involved for a number of years in an increasingly unambivalent and pleasurable symbiotic relatedness, had come to radiate, now—with disconcerting suddenness, so it felt to me—a self-containment which, by all logical standards, was a most welcome therapeutic development. Instead of her making unceasing efforts for me to be all persons to her and to satisfy her every need almost before it arose, she now spent the hours with me in saying little, but mainly in looking at me calmly, appraisingly, and objectively. She was not being actively rejecting to me, in either word or facial expression, as she had been on innumerable occasions much earlier in our work, particularly during the phase of ambivalent symbiosis. But I felt a distinctly unpleasurable sense of being apart from her; I could not help feeling rejected in the face of a development which I knew represented, for the first time, the establishment of a genuine sense of self on her part.

For the patient to become firmly established as, subjectively, an individual person, he must come to accept that, although he can contribute to the healing of other persons—including his therapist's—psychological difficulties, he cannot cure them in any total sense, and therefore does not have to hold himself responsible for curing them. He can proceed, therefore, with the getting-well process, the process of becoming an increasingly healthy person, without *guilt* for being, and increasingly becoming, a separate individual. This is one of the dividends which the relinquishment of infantile omnipotence yields to the patient—a relinquishment which is part of the relinquishment of the mother-infant symbiosis in the transference.

From the therapist's view, he must come to accept that, although the patient has been of deeply personal help to him, the patient cannot totally 'cure' him—that he will have to struggle toward increasing maturity, increasing personal integration-and-differentiation, in future courses of work with the patients who will succeed this one, and he may glimpse, now, the basic truth—if it be that, and I surmise that it is—that the ideal of 'complete maturity' is only one of the disguises worn by the persistent striving, within him, toward infantile omnipotence. Loewald (1960*b*) speaks of the valuable role, in super-ego formation in healthy development, of manageable increments of disillusionment. The successful resolution of the symbiotic phase of therapy with the schizophrenic patient requires, likewise, that each person be able to integrate his disillusionment about his own, and his partner's, powers, shrunken now from omnipotent to life-size proportions.

It has seemed to me, both in my own work and in the material reported by colleagues in supervision and elsewhere, that the patient has first to demonstrate to himself that the therapist is not omnipotent, but rather—at this moment, at least—totally helpless, before he can feel it permissible to go ahead and function, capably, as an individual. This seems in part a function of the vulnerability to guilt-about-being-a-separate-person to which the schizophrenic person—and, I believe, to a lesser extent the neurotic person also—is so prone. It is as though he has to exhaust every possibility of getting help from the therapist—about whatever issue is at hand—before he can himself allow his own constructive potentialities to come to the fore, and meet the issue at hand in his own functioning individuality. Thus it is no coincidence that the emergence of the patient's individuality tends to occur in a setting of the therapist's feeling more than usually helpless in the situation. One can think of it from the viewpoint, also, that no one, whether adult patient or healthy child, would give up a therapist (or, respectively, a parent) who is, as far as can be determined,

omnipotent; human beings are, if nothing else, practical, and this would be simply impractical: it would make no sense to individuate oneself from such an omnipotent being.

It is worth noting, further, that if the therapeutic relationship is to traverse successfully the phase of resolution of the symbiosis, the therapist must be able to brave not only the threats of suicide or psychotic disintegration on the patient's part, and of the professional and personal destruction to himself which might be a correlate of such outcomes; he must brave also the threat, which seems at times to be of a comparable order of magnitude, that the patient will, after these arduous years have passed and the homestretch is in sight, change therapists. It is as though the patient, by presenting the therapist with this threat of separation and finding that the latter can face it squarely without resort to panicky efforts to re-establish their erstwhile mother-infant symbiosis, gains the reassurance that the therapist will allow him to become a person in his own right, and to regard the recovery from psychosis as predominantly the patient's own achievement, rather than as a feather in the therapist's cap.

An important step in individuation for one of my patients, with whom I had been working for seven years, occurred when I allowed her to use my telephone, during one of her sessions with me, to call the Director of Psychotherapy for an appointment to discuss her desire for a change of therapists. In retrospect I have seen this as a crucial experience for her, that I freely allowed her to do this although her changing therapists would have meant a great personal loss to me, and although I felt it quite possible that she might succeed in that endeavour.

Incidentally, my readiness to face this development was, I think, one factor which enabled her to explore soon afterward, in her sessions, her desires, repressed since childhood, for a different set of parents. This transference-development tends, I think, to occur comparatively late in treatment, when the therapist is likely to think the patient pain-

fully ungrateful for wanting, in the transference, a different therapist. I have mentioned elsewhere (1961*a*) how apt the patient is to press for a change of therapists just at a time when he is threatened with the beginning recognition of how greatly he himself has changed, a recognition which tends to disrupt his still-tenuous sense of personal identity; in the context of this paper, the patient tends to flee from the recognition of his having undergone the great change of individuation—tends, in Erich Fromm's (1941) phraseology, to flee from the freedom of individuality, by seeking a symbiotic relationship with a new therapist.

The resolution-of-symbiosis phase is always complicated, often to a marked degree, by the resistances which various persons in the patient's life between therapeutic sessions, including the family-members, various of the nursing personnel and, it may be, various of his fellow patients, pose to his becoming a separate person and depriving them, therefore, of such symbiotic gratifications as the therapist himself has come to know, and reluctantly to relinquish, in the transference-relationship. It is by now a truism that the family-members, no matter how genuinely fond of the patient and devoted to him they are at a conscious level, are particularly likely to withdraw him from the hospital just at the point when his individuation is promising to become established; and the therapist is not the only member of the hospital personnel who inevitably acquires, over the years, a deep emotional investment in the patient's remaining ill and symbiotically oriented toward the more significant ones among his fellow human beings. But that aspect of the matter has been discussed already in the literature to a considerable extent, and any detailed examination of it would carry us beyond the intended focus of the therapeutic relationship itself with which I am primarily concerned here.

(E) THE LATE PHASE

This phase extends from the resolution of the therapeutic symbiosis up through the com-

pletion of the therapy. It is a long phase, for only with the resolution of the symbiotic mode of relatedness is the patient capable of genuine object-relatedness and able, therefore, to cope with the matters with which psychoanalysis of the neurotic individual ordinarily deals. Only now, that is, is he ready for psychoanalysis; thus this phase requires a number of years of continued work.

Now that his symbiotic mode of relatedness has been resolved, the patient becomes involved in a better differentiated, more selective, process of derepression of identifications from the past, with acceptance into his own ego of those identifications which are predominantly useful to him, and relinquishment of those which have proved unuseful, or pathological. He shows a similar capacity for forming, or rejecting, part-identifications with figures in current life, including the therapist. This process is well described in some of Erikson's (1956) words about identity formation, where he says that this '...arises from the selective repudiation and mutual assimilation of childhood identifications, and their absorption in a new configuration...'.

The patient now evidences increasingly much, not only in therapeutic sessions but in his daily life, the demeanour of a healthy child or adolescent; he belatedly evidences, that is, those normal developmental phases which, because of the severity and early onset of the schizophrenogenic personality-warpage, he had barely known in his biological childhood and adolescence. From a childhood which earlier in therapy he had experienced as unrelievedly black, he now remembers, with powerful affects of love and grief, positive experiences with his parents and other figures in his childhood, and there is a consequent freeing-up of useful identifications with those persons' strengths. Thus the strength which helps him to become well derives not only from his positive identifications with the therapist and other figures from current life in the hospital; there is also, and most importantly, this ingredient of his making contact with the strengths in his own past.

To an extent far greater than in the neurotic, however, the patient is likely for at least several months to present himself—and no doubt genuinely to feel—as a naïve little child who doesn't know anything, and who therefore needs to be taught all over again, and correctly this time, how to live. The therapist, aware that so much of what the child learned from family-members was indeed pathological and that a high degree of social isolation outside the family prevented his learning innumerable things about everyday life which were common currency among his age-mates, will be under extraordinary pressure to assume the function of a teacher or counsellor. I believe that the patient may benefit from, or at least not be greatly harmed by, the therapist's assuming on occasion such a function. But the therapist rapidly finds himself, here, on thin ice, in danger of losing touch with the only consistently solid function he has in the patient's life—that of psychotherapist. The words of Spitz (1959) concerning psychoanalysis are forcefully applicable here, and the therapist will do well to recall them:

The essence of psychoanalytic treatment is that it does not direct, advise, educate. It liberates the personality and permits it to make its own adjustments. . . . No directive or educative measures in the commonly accepted sense of the terms are necessary. Indeed, they can only disturb the natural process, which is so highly individualistic as to make it impossible for the particular therapist to direct it in its minute details. Any direction required is provided actually by the transference situation. This insures a process of developmental unfolding free from the anxieties, perils, threats of the original situation.

The patient has been exposed in actuality, prior to the psychotherapy, to more of adult-life experience than he realizes as yet, and the naïve-child orientation is eventually seen in retrospect to have represented a powerful, though unconscious, striving to keep the therapist enshrined as an omniscient parent, while himself avoiding the fullness of his childhood disillusionment with the parent(s) and avoiding, thus, the responsibility for his

own going on to adulthood. If the therapist persists in adhering to his psychotherapeutic function, the next unfolding of the transference consists, in my experience, in the patient's deeply disillusioned and scornful conviction that the therapist is in no measure qualified to be an omniscient general manager of the patient's life but is, quite the contrary, crazy. This is the development which Hill (1955) evidently had in mind in describing the schizophrenic patient's experience of the conclusion of therapy:

...one hears very little about gratitude from these patients. What happens is that, in the process of taking in the goodness [i.e. identifying with the good qualities of the doctor] and incorporating it actually into himself, the patient manages to make the sort of split that is comfortable to all of us. He is good, and the badness is left with the doctor. Even the illness is left with the doctor. Sometimes it is quite striking that the patient comes to believe that the doctor is thoroughly psychotic, quite in the fashion in which he himself has been psychotic.

This is a very regular development in my work with patients, as I have reported previously (1959*a*); but, unlike Hill, I feel it essential for the patient's future welfare that the psychotherapy be pursued far beyond this point, until the craziness has been well resolved, rather than simply left in this projected form upon the therapist. It is subsequent to this that there is a differentiation, in the transference, of those intense affects—murderousness, envy, loneliness, fear, and above all deeply denied love (Searles, 1958*b*)—which lay behind the parents' craziness. The added ego-strength which the patient has acquired in the course of his psychotherapy enables him to experience derepressed feeling along these paths with a clarity of delineation, and depth of intensity, which he could not subjectively experience previously—no matter how intense were the affects which he acted out during the phase of ambivalent symbiosis. And the therapist is unprecedentedly free now to experience within himself, and on crucial occasions to express, the reciprocal feelings inherent in these transference-positions in

which he finds himself, with a minimum of the conflict and guilt which had been so prevalent during the ambivalently-symbiotic phase.

It is during this late phase of the therapy that the onset of the patient's psychosis becomes clarified; he is finally able to experience, and integrate, the emotions which at that much earlier date had had to be repressed, and defended against by the advent of psychosis. For example, I have had the experience, at once fulfilling and somehow awesome, of finding that a patient who had become schizophrenic at the age of fifteen and had spent nineteen years predominantly in mental hospitals, had now reached a point, after ten years of intensive psychotherapy with me, where the secondary elaborations of her hebephrenic illness had been sufficiently unravelled so that the material of her original delusions was now coming to the fore, but in a way progressively understandable to both of us.

As the patient makes emotional contact with the various previously repressed areas of his past experience, bit by bit, he eventually reaches the realization that, despite all the years of illness, as one patient expressed it with great relief, 'I'm still myself'. In other words, there is eventually established a sense of continuity of identity, combining the person he felt himself to be prior to the psychosis with the emotions and attitudes manifested in the psychosis, long unacceptable to the conscious ego, but now accepted as a part of it. It is on the basis of such a newly achieved ego strength and such a firmer sense of personal identity that he is now able to take his stand and assess the personalities of figures from present and past life. I remember how impressed I was with one schizophrenic woman, for example, when after three years of therapy she became able to express, in a single breath, her realistic disapproval of certain qualities in her mother, in her father, and in me. Earlier in our work she had possessed far too little of a sense of individuality to be able to objectify these three so-important figures, so clearly and simultan-

ously. She became, as do other patients in the late phase of the work, equally able to express admiration and fondness toward parents and therapist.

Because the therapy of these patients usually requires a considerable number of years, the therapist may find it particularly difficult to be receptive to the expression of some feelings which the patient can face only after several years of treatment. The therapist, keenly aware that, say, five or six or seven years of intensive psychotherapy has elapsed, may feel threatened and therefore impatient at the patient's finally becoming able to explore the depths of the latter's discouragement and despair, or—as I mentioned before—wish for a different parent in the transference, or regressive strivings. It is only through the therapist's being fully aware of the therapeutic progress represented by the patient's becoming conscious of these feelings, and able now to express them verbally rather than having to act them out as in the foregoing years of the treatment, that he is able to help the patient on toward completion of the therapeutic investigation, rather than toward a repression of these feelings for an indefinite time longer.

Similarly, because the therapist has seen the patient to be, earlier in the therapy, such a deeply fragmented person, he tends to retain a lingering impression of the latter's fragility, an impression which may interfere with his going along at the faster pace which the patient, a very different and far stronger person now, is capable of setting. But even this memory-image of the fragile patient, carried with the therapist, has a natural function in the course of the psychotherapy, for it is only very late in the work that the patient himself is able to realize how very ill, how very fragile, he indeed once was; until he becomes strong enough to integrate this realization into his self-image, the therapist has to be the bearer of this piece of the patient's identity. This process is analogous to the well-known phenomenon in which each major forward stride in the patient's therapeutic growth is accompanied, or presaged, by the therapist's suddenly seeing in the patient a

new and healthier person (Searles, 1958c, 1959b); there, too, the impact of the development falls primarily, for a time, upon the therapist rather than the patient. The patient himself, because his sense of identity is still, during the earlier therapeutic phases to which I am referring at the moment, relatively tenuous, is easily overwhelmed—in one patient's words, 'Knocked out'—by the realization of the extent to which he is now changed, even though this change be, in our view, a most beneficial and welcome one.

Another characteristic of the late phase—and I am not attempting to describe, here, all such characteristics—is the circumstance that various of the patient's adult strivings may be found more deeply repressed than his infantile strivings. That is, it may well prove easier for the therapist to contemplate (Searles 1957), and easier for the nursing-personnel to recognize and at least partially gratify, various of the patient's infantile and small-child oral needs, than to help him to face squarely his powerful adult-desires, mobilized and given shape in the course of the psychotherapy but still painfully thwarted by reason of his long hospitalization—his desires to marry and procreate and bear adult responsibilities. Sometimes the patient's expression of such desires, particularly if he or she has been so long hospitalized that various of these must be accepted as losses or deprivations which can never be made up, is at least as poignant for the therapist to hear as were the earlier-expressed yearnings for infantile and childlike gratifications. He realizes to what an extent, for probably many months now, it is the more *mature* areas of the patient's personality which have been the more deeply repressed ones (Searles, 1961a), and that, in contrast to some of the views expressed by Freud (1915), the maturation-process is so deep-reaching that it leaves no changeless core of the personality, no eternally-infantile id, unchanged by it.

The evolution of the reality-relatedness between patient and therapist, over the course of the psychotherapy, is something which, so far as I know, has received little more than passing

mention in the literature (Searles, 1961d). Hoedemaker (1955), in a paper concerning the therapeutic process in the treatment of schizophrenia, stresses the importance of the schizophrenic patient's forming healthy identifications with the therapist, and Loewald (1960a), in his paper concerning the therapeutic action of psychoanalysis in general, repeatedly emphasizes the importance of the real relationship between patient and analyst, but only in the following passage alludes to the evolution, the growth, of this relationship over the course of treatment:

... Where repression is lifted and unconscious and preconscious are again in communication, infantile object and contemporary object may be united into one—a truly new object as both unconscious and preconscious are changed by their mutual communication. The object which helps to bring this about in therapy, the analyst, mediates this union. . . .

It has been my distinct impression that the patient's remembrance of new areas of his past—his manifestation of newly derepressed transference reactions to the therapist—occurs only hand in hand with the reaching of comparable areas of feeling in the evolving reality-relatedness between patient and therapist (1958b). For example, he does not come to experience fond memories of his mother until the reality-relatedness between himself and the therapist has reached the point where the feeling between them has become, in reality, predominantly positive. Loewald's words, quoted above, imply to me that an increment of transference-resolution slightly antedates, and makes possible, the forming of each successive increment in the evolving reality-relationship between patient and analyst. It has been my impression, by contrast, that the evolution of the reality-relatedness proceeds always a bit ahead of, and makes possible, the progressive evolution-and-resolution of the transference, although to be sure the latter, in so far as it frees psychological energy and makes it available for reality-relatedness, helps greatly to consolidate the ground just taken over by

the advancing reality-relationship. Loewald (1960a) thinks of it that

... The patient can dare to take the plunge into the regressive crisis of the transference neurosis which brings him face to face again with his childhood anxieties and conflicts, *if* he can hold on to the potentiality of a new object-relationship, represented by the analyst.

But it seems to me that this new object-relationship is more than a potentiality, to be realized with comparative suddenness, and *in toto*, toward the end of the treatment with the resolution of the transference. Rather it is, so it has seemed to me, constantly there, being built up bit by bit, just ahead of the likewise evolving transference-relationship. Pertinent here is Freud's (1922) having pointed out that projection—which is, after all, so major an aspect of transference—is directed not 'into the sky, so to speak, where there is nothing of the sort already', but rather on to a person who provides some reality-basis for the projection.

In the final months of the therapy, the therapist clearly sees the extent to which the patient's transferences to him as representing a succession of figures from the latter's earlier years, have all been in the service of the patient's unconsciously shying away, to a successively decreasing extent, from experiencing the full and complex reality of the immediate relatedness with the therapist in the present. The patient at last comes to realize that the relationship with a single other human being—in this instance, the therapist—is so rich as to comprise all these earlier relationships, so rich as to evoke all the myriad feelings which had been parcelled out and crystallized, heretofore, in the transferences which have now been resolved. This is a process most beautifully described by the Swiss novelist Hermann Hesse (1951) winner of the Nobel Prize in 1946, in his little novel, *Siddhartha*. The protagonist, in a lifelong quest for the ultimate answer to the enigma of man's role on earth, finally discovers in the face of his beloved friend all the myriad persons, things, and events which he has known, but incoherently before, during the vicissitudes of his many years of searching.

It is thus that the patient, schizophrenic or otherwise, becomes at one with himself, in the closing phase of psychotherapy. But although the realization may come to him as a sudden one, it is founded on a reality-relatedness which has been building up all along. Loewald (1960a) in his magnificent paper to which my brief references have done less than full justice, suggests, as I mentioned, something of the role which transference-resolution plays in the development of this reality-relatedness. I suggest that the evolution of the 'countertransference'—not countertransference in the classical sense of the therapist's transference to the patient, but rather in the sense of the therapist's emotional reactions to the patient's transference—forms an equally essential contribution to this reality-relatedness. This paper has been primarily an attempt to describe the evolution of what might be called—in this special sense—the therapist's typical 'countertransference' to the schizophrenic patient, over the course of successful psychotherapy.

CONCLUDING REMARKS

In my attempt to highlight the paramount place which emotions—emotions in the therapist as well as in the patient—hold in the psychotherapy of schizophrenia, I would not wish to leave the impression that the therapist should strive to be immersed continually in a kind of emotional blood-bath. On the contrary, as I described it at the outset, the emotionally charged transference-evolution which has been traced here can develop, and run a relatively unimpeded course, only if the therapist is sufficiently sure of his capacities for feeling so that his basic emotional orientation can be an investigative, rather than for example a compulsively 'loving', orientation. Moreover, each of these patients—and, I think, this is true to a lesser degree of the neurotic patient also—needs in the course of the therapy to project upon the therapist the subjectively unfeeling, nonhuman and even inanimate, aspects of himself, and thus to see

his therapist, in the transference, as the representation of the parents who were, to the child's view, incapable of human feeling, as has been the patient himself in his own view (Searles, 1960, 1961*b*). Only by thus re-externalizing his pathogenic introjects can the patient make contact with his own feeling-capacities and come to know, beyond any further doubt, that he is a human being. This aspect of the transference, this aspect of the healthy reworking of very early ego-differentiation, cannot be accomplished unless the therapist is able to be self-accepting while spending hour after hour without finding in himself any particular feeling whatever toward the patient. He must be sufficiently sure of his own humanness so that he can endure for long periods the role, in the patient's transference-experience, of an inanimate object, or of some other percept which has not yet become differentiated as a sentient human being.

In the course of writing this paper, the realization has dawned upon me that the therapist recurrently experiences guilt in reaction to the arousal of one or another kind of emotion in himself, during the course of his

work with the schizophrenic patient, on the basis of a rekindling of the therapist's infantile-omnipotence. Such a temporary regression on the therapist's part, to the level of infantile-omnipotence, is his major unconscious defence against the realization, and deep and consistent acceptance, of the fact that not only the patient but he also is in the grip of a process, the therapeutic process, which is comparable in its strength to the maturational *process* in the child—which is, indeed, this same process in a particular context, the context of psychotherapy of the adult schizophrenic person. The more experienced and confident the therapist becomes in this work, the more deeply does he realize that this process is far too powerful for either the patient or himself to be able at all easily to deflect it, consciously and wilfully and singlehandedly, away from the confluent channel which it is tending—with irresistible power, if we can give ourselves up to the current—to form for itself. When the therapist sees this, he realizes how illusory has been his subjective omnipotence, but also how groundless has been his subjective guilt.

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A comparative study of the mother-child relationship in schizophrenia

I. The interview

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'...the group of schizophrenias are regarded as representing genetically determined, although sometimes environmentally provoked, biochemical disturbances of cerebral function' (Tait, 1958). This definition is fairly representative of the present outlook on schizophrenia, suggesting as it does both the non-specificity of the syndrome and the wide scope of the aetiological factors which are being considered by contemporary workers. In recent years the volume of literature on the possible organic basis of schizophrenia has been matched by the growing number of investigations aimed at isolating the environmental provoking factors and assessing their significance. The majority of these investigations has focused on the relationship between the developing schizophrenic and his mother, seeking to find in this relationship some correlates with the later emergence of the psychotic condition. The broad hypothesis behind such work is that there exist certain factors which distinguish the mother-child relationship of the future schizophrenic from the 'normal' relationship which functions in the case of non-schizophrenics. The object of the present study will be to examine the evidence reported in support of this hypothesis and to present an attempt to assess its validity.

BACKGROUND AND PREVIOUS LITERATURE

Earlier conclusions regarding the type and effect of the maternal influence on the schizophrenic were derived from the clinical impressions of psychiatrists who had dealt with schizophrenic patients and their relatives,

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usually in a psychotherapeutic setting. The views expressed vary from tentative opinions that the maternal influence is a malignant force of some aetiological significance to the more extreme interpretation typified by the following emphatic comment of Rosen—'Schizophrenia is a disease which has its conception somewhere between birth and prior to termination of the pre-verbal period and is caused by the mother's inability to love her child' (Rosen, 1953).

The acceptance of the maternal influence as a prime factor in the aetiology of schizophrenia has become so widespread in certain sectors of American psychiatry that the term 'schizophrenogenic mother' has become a familiar sight in the recent literature. This rather obnoxious term describes the mother whose attitude to her child is so pathological as to cripple the child's psychical development and lay the foundation of the later schizophrenic breakdown. In spite of the frequent references to the role of the 'schizophrenogenic mother', few of its users have attempted to define the term or to formulate their impression of the mother's personality in a detailed manner. Beyond a general agreement that these mothers tend to lack emotional warmth and that they attempt to manipulate others, one finds a distinct lack of detail behind the clinical stereotype. A notable exception here is provided by the late Lewis Hill's clear exposition of his observations based on many years experience with schizophrenic patients and their families.

Now, if we endeavour to reconstruct some of these observations that we have made from our experience of schizophrenic patients and their mothers, we can imagine what must have been the life-situations of the mothers. It would appear

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that they were dominated by their own mothers, who were opposed to sex and men and who were competitive both with husbands and with children for dominance in the household. They declined to grow old and let these children of theirs mature into motherhood. These mothers of schizophrenics, as a group, might be called 'obsessive-compulsive'. They are abnormally interested in cleanliness and propriety. They are idealists concerning marriage and love, although they seem to be quite vague about sexual matters. One would suspect that they are examples of Freud's observation that at the centre of the obsessive structure there is an exquisite hysteria. It appears in getting the histories, with the questions about the mother in mind, that the mother either was a frigid or an immature person without capacity and tolerance for mature psychosexual intimacy with another person or, if she had such capacity, for one reason or another it was in eclipse at the time of the patient's infancy.

Finally, with regard to the mother's attitude towards the child, Hill declares:

These mothers love their children who become schizophrenic not only excessively but conditionally. The condition for their love is one which the schizophrenic child cannot meet. If he does, to a degree, meet it, in doing so he sacrifices his realization of a personality of his own, independent of hers... (Hill, 1955).

Repeated statements regarding the maternal role in schizophrenia have stimulated a wide variety of investigations, many of which are so severely limited by methodological deficiencies as to add little in the way of verification to the candidly subjective opinions represented by Hill's comments. The conclusions reached by such studies might be challenged on the ground of the absence or inadequacy of normative control data (e.g. Kasanin, Knight & Sage, 1934; Lidz & Lidz, 1949; Reichard & Tillman, 1950; Wahl, 1954; Tietze, 1949). The investigation reported by Kohn & Clausen (1956) illustrates the dangers of accepting the findings of studies which have used patients and controls of different socio-economic backgrounds. Of the investigations which have included a comparative control group few have extended their comparison to include

patients other than schizophrenics. Where such precautions have been taken (McKeown, 1950; Gibson, 1958; Alanen, 1958) the results have been less conclusive, suggesting that a number of the so-called pathological aspects of the maternal relationship are not specific to schizophrenia. Finally, one might object to the lack of attention paid to the psychodynamic factors inevitably affecting the outcome of such studies. Any interview which seeks to elicit information on such emotionally laden areas as child-rearing, marital adjustment, intra-family relationships, is likely to arouse personal anxiety against which the subject will defend himself by a variety of manoeuvres. Such consideration will be particularly relevant in the case of the experimental subjects who are influenced by all the complex reactions arising from having a son or daughter suffering from a severe psychiatric illness. The possibility of penetrating these defences, and obtaining a reasonably valid picture of the family situation, on the basis of a single interview or from a questionnaire, seems highly improbable. A notable exception to this objection is contained in the work reported by Gerard & Seigel (1950) who were fully aware of the need to establish (with their subjects) a relationship which would minimize their defensive anxiety.

In spite of the methodological limitations of many of these studies there is a fair measure of consistency in some of their findings. Most investigations describe the mother's attitude to her schizophrenic offspring as over-protective, although this term is seldom clearly defined. In contrast to some of the earlier views it would seem that the most normal period of mother-child relationship is that of infancy, the mother's pathological behaviour emerging clearly only in the later childhood and early adolescence. Most investigations describe a disturbed marital relationship in the case of schizophrenic families, the mother being seen as the dominating and manipulative head of the family where the father exerts little or no influence. A highly abnormal and frigid attitude towards sex on the part of the mother is also commonly reported and many of those

studies describe the variety of ways in which the mother's abhorrence of sexual matters is transmitted to the child. In their relations with others these mothers are described as remaining isolated from the rest of the social group and restricting themselves to their home and their family. Some authors, while accepting a degree of pathological uniformity in the mother-child relationship, suggest that this may be explained as a mother's reaction to rearing a schizophrenic offspring who, from early infancy, frustrates her attempts at mothering by abnormally negative modes of response. According to this view the abnormal behaviour of the mother is seen to be a result, rather than a cause, of the patient's condition. One way of assessing this reaction would be to examine the mother's personality and life history prior to the child's birth, but unfortunately the data thus far collected do not lend themselves to such an analysis.

We might conclude then that previous studies in this field tend to affirm the presence of a pattern of pathological behaviour within the mother-child relationship in schizophrenic families. Reports on the nature of this relationship would appear to agree by a large extent with the clinical descriptions, put forward by Lewis Hill (1955).

THE PRESENT STUDY

Method and procedure

At the start a decision had to be made between the two alternatives of planning a detailed investigation of a relatively small group of subjects or a more superficial study of a much larger group. In order to avoid as far as possible the misleading impressions which may easily result from superficial contact it was decided that the subjects should be seen over a reasonable period of time to allow some degree of rapport to be established. It was felt that the gain in quality and accuracy of this approach might outweigh the more statistically acceptable but psychologically less reliable information yielded by the alternative type of approach.

As previous investigators have tended to confine their comparison to control groups of 'normal' mothers, it was decided to include in this study a second control group of mothers of neurotic patients to act as a further check on the specificity of the family background in schizophrenia. The mothers interviewed were all in their fifties, the mean ages of the control, schizophrenic and neurotic groups respectively being 59.1 years, 56.1 years, 54.8 years. The comparative ages of the patients were 29.1 years, 28.7 years and 24.2 years. The study was also confined to families falling into social classes III and II, this being assessed on the basis of occupation, income and educational background.

The *schizophrenic* group consisted of well established schizophrenic patients resident in the mental hospital where the work was carried out. All had spent from 2 to 8 years in hospital without any marked deviation from the schizophrenic pattern being observed. A final, and obviously necessary qualification, was that the mother should be alive, not infirm and within 'reasonable geographical distance'. The mothers were initially contacted by letter requesting their co-operation. Only two refused this initial request, both on genuine grounds of illness and there were no subsequent withdrawals. The co-operation of 20 mothers of schizophrenic patients was enlisted in this way. The *neurotic* group was composed of 20 mothers of patients attending a local clinic for the treatment of psychoneurosis. Care was taken to exclude any patients whose symptoms were in any way suggestive of early schizophrenia. Here there were 14 refusals to the initial request for the mothers' co-operation, but none of the 20 subjects who did agree withdrew during the course of the investigation. The *normal control* group presented the greatest problems in recruitment but 20 suitable subjects were eventually found who appeared to answer all the matching criteria. In order to complete the list of 20 suitable subjects, however, a total of over 40 subjects had to be contacted, there being 24 initial refusals. A further 7 subjects

terminated their interviews before completion, their material being 'written-off' and new subjects enlisted to make up the final list of 20 subjects.

From what has been said it will be obvious that the control group in this investigation can in no way be taken as representative of 'normal' mothers in the community. The small number of subjects included in the groups would, of course, act against the group being a representative one, even if the other difficulties had been overcome. In the case of the patient groups, the families were already involved in the situation and the mothers thus had some incentive in agreeing to be seen by the investigator. This incentive is, of course, absent in the case of the non-patient group and one is faced with the apparently insoluble problem created by the fact that each of these subjects must volunteer their co-operation. It is, of course, impossible to assess the complex reasons which cause people to agree to co-operate in an investigation of this type, although this might make a useful and informative study on its own. Experience showed that some of the subjects who either excused themselves originally or who withdrew during the course of the interviews did so because they were disturbed by the probing nature of the investigation. Others, however, may have refused to act as subjects on quite different grounds and for reasons which one could not describe as unhealthy or irrational. In other words, then, we are faced with the rather discouraging conclusion that the 'normal' subject in psychological experiments of this description can never be taken as representative even if every variable is considered by the investigator in his selection procedure. The very fact that these people agree to be interviewed and to discuss personal aspects of their family life in itself biases the information which they give. The groups in the present investigation are relatively small and it may be that some of these difficulties are diminished if large numbers are employed. One can equally well argue, however, that larger numbers may only tend to magnify the problem with the

further danger that the information yielded by larger groups tends to be more easily accepted as objective and accurate. The aura of respectability which surrounds the use of large group controlled studies in psychological research may be deceiving and dangerously authoritative if one does not take into account some of the factors which affect the composition of 'a normal control group'. It might, of course, be thought that we are indulging here in psychological 'hairsplitting' which does not greatly affect the limited aims of the present study. The normal control group corresponds with the two patient groups in age range, sex distribution, and socio-economic status. It may be considered 'normal' in so far as there is an absence of psychiatric illness in the families involved.

The subjects were examined during the course of six sessions, each lasting approximately 90 min. with an interval of one week between sessions. During the first two meetings no attempt was made to conduct a systematic examination, the main purpose being to create as positive a relationship as possible between the investigator and subject. Questions were limited to those seeking formal information regarding facts already available in the patient's case history. Reassurance was given where necessary and, in the case of the patient groups, this was considerably often. It might be objected that the interviewer's approach during these early 'warming up' sessions was, at best, a waste of useful time and, at worst, contrary to all standards of scientific objectivity. The answer to the first of these objections is to be found in the degree of defensive anxiety present in the original attitudes of the patient group which, if ignored, would certainly have greatly restricted the facts and opinions given later. In a number of cases such anxiety would have surely prevented the mother from attending succeeding sessions, particularly when it meant coping with a number of obviously searching personality tests. The formal standard interviewing was conducted during the third and fourth meetings, the last two sessions being devoted

to testing. This report deals only with an analysis of the interview material. The results of testing and their correspondence with the interview data will form the subject of a later report.

Analysis of interview responses

The interview material was analysed according to the system of comparative matching first introduced by Raven and since used successfully by other workers (McAdam & Orme, 1954; Orme, 1957). By this method the frequency of each response is calculated for each of the three group studies. Responses are considered as characteristic of one group, in contrast to another group if (a) they occur with at least a 25 % frequency in that group, and (b) appear with at least double the frequency in that group as opposed to the other group with which it is being compared. In the present study, where three groups are involved, it can be seen that a response, to be considered uniquely characteristic of any group, must occur with a frequency which is at least twice that of the incidence in either of the two remaining groups. In this manner it is possible to elicit a pattern of responses which is specific to either of the two patient groups, and also to extract the responses which significantly differentiate the two patient groups together, from the normal controls. This latter pattern representing the common ground between the neurotic and schizophrenic group includes responses which have in previous studies been described as specifically related to schizophrenic families, and we will first examine these findings. In reporting this analysis the significant response categories are printed in italics and are followed by some examples of typical reports which determine the final group incidence.

Responses characteristic of both schizophrenic and neurotic groups

A breakdown in toilet habits in later childhood is reported more frequently by both sets of patient mothers than by the normal controls. This tendency towards enuresis is more com-

mon in the early history of the schizophrenic patient, although its frequency is also significant in the neurotic histories. In recent years the value of childhood enuresis as a predictor of later adult maladjustment has been questioned and it is therefore interesting that it is found to be characteristic of the patients involved in the present study.

Similarities in the early childhood behaviour of the neurotic and schizophrenic patients are evident in the present analysis. Both sets of patients are, in comparison to the normal controls, more frequently described as having been *fastidious and particularly clean in their habits*. The majority of mothers in both patient groups stressed this aspect of the patients' early personality—'She was clean, perfectly clean, always clean—never dirty. She was always fussy about her appearance. You never saw her dirty or her clothes like her sister who was always getting messed up.' The mother's description frequently contained suggestions that the interest in hygiene and personal appearance was part of a general rather obsessional pattern. 'She was always very fussy when she was a child. For example, she was forever dusting the chairs with a feather duster and always drawing my attention to dust in the house which I had missed. If you gave her a drink she always inspected the cup and thought nothing of giving it back to you if it was chipped or not clean enough for her liking. I remember she used to even brush down her bed before going into it at night. At first we were amused at this sort of behaviour from a five-year-old but we soon began to feel that she was just a bit too fussy for a young kiddy.' The latter part of this description contains one main apparent difference between the two groups on the common obsessional pattern of behaviour. While the mothers in the neurotic group tend to disapprove of, or to have been concerned about, the child's behaviour, the mothers in the schizophrenic group imply acceptance and approval in their comments.

Nervous symptoms in childhood are reported with equal frequency in the neurotic and schizophrenic histories. The type of symptoms

described here cover the whole gamut of common childhood neurotic reactions, but most commonly reported are excessive temper tantrums, night fears, and a variety of temporary phobias. No differences between the type of symptoms reported by the two groups were apparent and there was a significant absence of any tendency towards early autistic behaviour in the reports of the mothers of the schizophrenic patients.

The child's first introduction to school is another situation which created difficulties in both patient groups. *Initial trouble in starting school* is more frequently reported in the schizophrenic group but is also present to a significant degree in the case of the neurotic group. His initial inability to find his place in the classroom group was frequently the object of concern, this being apparently due to the child being *shy and passive at school, lacking confidence in his own ability*. The mothers are inclined to describe the child's early school life as being over-shadowed by the victimization and bullying of other children and fears of the teacher's authority. Here again one can observe a difference in the mother's attitude to the situation. The neurotic mothers tend as a whole to have accepted the difficulties as being partially due to the child's inability to adjust to others. The schizophrenic mothers, however, tended to deny the child's inadequacy and approve of the factors which isolated him from others.

Agreement is again apparent in the types of interests reported in the histories of both patient groups. According to the mothers' reports these patients tend to show a keen interest in the theatre, cinema and television. They are also more inclined to be interested in music, either actively or passively through attending concerts or collecting recorded music. One might generalize their interests as being on the whole more solitary, passive, and directed more to the world of phantasy than in the case of the normal controls.

In the mother's own life history, the only common characteristic which distinguishes both patient groups from the normal controls

is the comparatively higher frequency of paternal loss through death during the informant's childhood. Seven of the schizophrenic group and five of the neurotic group declared that their father died before they themselves reached their tenth year. This factor is totally absent in the normal control group.

Responses specifically characteristic of schizophrenic group

The following pattern of responses can be said to be specific to the schizophrenic group in so far as their incidence significantly differentiates these responses from both the normal and neurotic groups. Included in this analysis (§A), are those of the interviewer's subjective impressions of the mothers which also reach the required criteria of significance.

A. The interviewer's impressions of the mothers

In her attitude to the interview situation she was ambivalent and manipulative. When first contacted these mothers invariably expressed their willingness to be interviewed in a most emphatic and often colourful fashion. The response here is typified by the following statement made by one of the group: 'I would go through fire, hell and floods for my girl. I would die for her if I thought it would help.' During the course of the interviews the subjects formed a relationship with the interviewer which might be described as being superficially a very positive one. As their relationship with the interviewer expanded, however, it became more and more a manipulative one. The mothers showed a great deal of interest in the interviewer's own life and particularly in his health. Six of the group at different times expressed the view that the interviewer was not looking well and should have a long holiday. Two of the mothers actually presented him with a tonic during a subsequent interview. Many of the mothers attempted to maintain their relationship with the interviewer outside of the interviewing sessions by extending invitations to their homes. During the third and fourth sessions

when the formal interviewing was carried out, the manipulative behaviour of the mothers became much more evident. The subjects often appeared for interview complete with diaries, albums, letters, and in fact anything that had once belonged to the patient. The mother would then attempt to read from these copious notes, thus controlling the trend of the interview and avoiding questions. Several of the subjects actually prepared themselves for the interview by writing down on paper everything they intended to say during interview. Another way of blocking the interviewing was for the subject to put forward a variety of complaints about the organization of the hospital and the treatment of the patient, asking the interviewer to take appropriate action. Their complaints about the hospital were usually extremely vehement and bore little relationship to the true facts. One of the most common fears expressed in respect of the patient's treatment while in hospital was, however, the more unusual one of the degree of sexual licence which many of the mothers imagined was allowed by the hospital authorities.

Many of the subjects *admitted disturbances in their health coincident with the interview period*. These included a number of apparently direct reactions to the interviews which were almost totally absent in the case of the other two groups. The actual disturbances here varied from physical disabilities to emotional distress. In three cases asthmatic attacks which had been dormant for years were re-activated at the time the subjects were being seen. Others reported having gastric complaints, high blood pressure, severe headaches and general tension. One of the mothers fainted when she was about to leave her home to attend an interview and had to be revived by her family.

The speech of most of the group was so rapid and spontaneous as to be irrelevant and incomprehensible. In these cases the subjects moved from one topic to another with bewildering rapidity, their replies invariably being irrelevant to the questions asked. When

one attempted to have the subject decipher a series of comments which had been incomprehensible, she was apt to move off on to another topic leaving the interviewer behind still trying to make some sense out of the previous remarks.

At the termination of an interview one was left in a mental fog, with the almost impossible task of unravelling a disconnected series of comments by the subject into some sort of logical order. Not only was the content of the speech incomprehensible, but the form and quantity alone invariable enough to *dominate the pattern of the interview*.

B. The mother's description of the patient's life history

In speaking of the patient's early habit training, *the mother could not remember when toilet training was initiated or completed*. In these cases the subject was unable to give even an approximate date for the training period, not even being able to state whether training was completed by the first or second year. Their difficulty seemed to amount to an almost complete repression of the toilet training period.

In discussing the patient's schooling there was a tendency for the mothers of both the patient groups to describe initial difficulties which occurred when the patient was starting school at the age of five years. In the case of the schizophrenic group, however, the mothers were apt to say that *these difficulties continued throughout his school days*. Some of the patients were reported to have been in trouble with the school authorities over truancy, while others were said to have stayed off school at the slightest pretext. Other difficulties in adjustment reported included strong aversion towards teachers and inability of the patient to find an adequate role within the classroom group. It was frequently reported that *the patient had a very poor and erratic work record after leaving school*. These patients were invariably reported as having been vocationally mobile. They had often been employed in a wide variety of disparate types of work. This

mobility was usually, but not always, in a downward direction. *The patient's leisure interests were described as being very limited and narrow.* Although the schizophrenic patient could not be differentiated from the neurotic patient according to the content of his interests, the range of his interests was invariably reported as being a more limited one.

In comparison with his siblings, the patient is often described by the mother as *being more dependent upon the mother.* Although there was a tendency for the neurotic patients also to be described as being dependent upon their mothers, the difference here is again in the mother's attitude towards the situation. The neurotic patient is more apt to be described by his mother as being *over dependent* upon his mother. In the schizophrenic group the mothers are more inclined to accept and actively encourage the child's dependency and by their behaviour effectively frustrate the child's attempts to be more independent as he develops. One mother when declaring proudly that her daughter had always found it best to rely on her guidance gave the following illustration. 'When she was older she decided that she wanted to pick her own clothes. She said the clothes I bought were too young for her and I was trying to keep her like a child. I let her buy a dress herself, but when she came home I made her try it on and showed her herself in front of a mirror. She looked so funny I called a neighbour in and we had a good laugh at her. After that she saw it was best to have me along to advise her and choose her clothes.' Although the patient is described as being the more dependent member of the family, he may also be said to be *unaffectionate in his relations with his parents.* There is a tendency for the mother to add that *she herself is undemonstrative and unaffectionate* in nature. Again, although the patient's shyness and self-consciousness in company is reported with equal frequency in both the schizophrenic and neurotic groups there is a distinct difference in the mother's attitude towards this aspect of the child's behaviour. In the neurotic group the

mother's comments indicate that they wished their child to be more outgoing and at ease in company and encouraged it, although not always successfully. In the schizophrenic group, however, the mothers again indicate their approval of the patient's limited relationships with others. 'She didn't have many friends. She thought she was superior to everyone, and in most cases she was. I was quite pleased to see that she was so selective. She was better than most of the other children around us, so it was really a good thing she spent most of her time on her own.'

In speaking of the patient's relationships with the opposite sex, the mother was inclined to indicate that *he had no interest in the opposite sex.* There is again a tendency for the mother to *approve of this lack of interest*, as the following three statements illustrate. 'She never liked men. She was modest and no one could take liberties with her. Even if a boy held her hand she would tell me. She had one man but I didn't trust him. He was one of these men-of-the-world types. I asked him what his intentions were, but he saw I would stand for no nonsense and left. I made sure she wouldn't be tricked by any man. I'd rather see her dead than ruined. She was always instinctively aggressive to men. She was always so pure.' Another mother described how she had discovered that her son had taken a girl out on a few occasions at the time when he was a university student. She said that she had always believed in allowing him to make his own decisions so she merely faced him with the alternative that he either stopped seeing the girl or have his university fees stopped. The boy took the former course and never again attempted to seek the company of a girl.

C. *The mother's description of the patient's illness*

The mothers were inclined to regard the patients as having been 'normal' until their illness. In spite of the deviant behaviour patterns reported during the patients' earlier development, the mothers of this group tended to assert that the son or daughter was

psychiatrically normal until the sudden and unexpected onset of the schizophrenic symptoms. From their point of view the history of the illness is a relatively short one. In speaking of the patient's illness *the mother was inclined to consider the illness to be directly due to either loneliness caused by absence from the home or to a variety of sexual matters.* One of the mothers described how her son had visited a theatre with a girl a short time prior to the onset of his illness. She went on to say, 'It was one of these American things with girls and risqué dialogue. The sort of thing that if you had none of these feelings in you it would bring them out. Maybe the girl knew her way around a bit more than my boy and something may have happened after the show that he would think sinful. Maybe it was worrying about that that might have brought on this illness.' The show in question was, in fact, 'Annie Get Your Gun'.

D. *The mother's description of her own life history*

Speaking of her own family background, the mother was inclined to report that her parental home *was disrupted through separation, divorce, or the death of one parent*, this having occurred during the informant's childhood. In the case of seven of the thirteen subjects involved, it was the informant's father who died when she herself was under the age of ten. Of the remaining cases involved, three of the subjects' mothers had died and a further three had left the home through separation or divorce. Discussing her parents, the informant was apt *to regard her own father as being either a very weak character or unapproachable and distant.* The father's weakness here was seen in his lack of ambition and drive. 'Father was always going to do something but never did it. He was just a bit too placid and easy going. He never got anywhere although he had the ability and could have. I like people who know where they're going and make some attempt to get there.'

Looking back on her childhood the mother tends to describe herself as being *sensitive and shy as a child.* 'I was like my boy in that respect when I was young. I always felt ill at

ease in company and I was terribly sensitive. If anyone criticized me I was apt to cry and because of this I think I avoided company a lot.' The mothers are inclined to say that *their childhood was on the whole unhappy.* 'I never really had a childhood. I was always at home doing housework. We didn't get out much at night and I think I must have been lonely. I certainly wouldn't like to live my childhood over again.' 'They say that your childhood is the happiest time of your life. All I remember as a child was wanting to be old enough to get away from home.' Where the informant was working *she tends to express regret at not having continued her career.* A number of these mothers felt that their latent abilities had never been developed and that they could have enjoyed success in their chosen vocation if this had not been interrupted by their marriage. The following comment, although rather melodramatic, is illustrative of this trend. 'I was always such a lovely singer. If I hadn't married I might have been another Patti. I had the talent, the energy and the drive to get to the top if I hadn't got married. Oh! What a frustrated life I have had.'

Regarding their relations with others in general, the subjects are inclined to say that in their adult life before marriage *they have never enjoyed company, had few social interests and preferred to be alone.* This aversion to company and social activities is also evident in the life the mothers have led since their marriage. Here they invariably report that *their interests centre narrowly on the family and the home.* The narrowing of the mothers' interests on the home to the exclusion of all else is perhaps best typified by the following comment made by one of the mothers during interview. 'I used to look forward each day to the hour of 10 o'clock. At that time I always locked the storm door and then the inside door and then I would say to myself, "Now I've got these three safe here from the world".'

In speaking of their husbands the subjects are apt to complain that *he avoids responsibility in the home and that he is lacking in ambition and drive.* It would be a pity to leave this topic

without mentioning the subject who, after describing her husband as a 'stupid little nonentity', went on to say, 'He's such a little nonentity around the house that when I'm cleaning up I often find myself dusting him along with all the other ornaments.' Speaking of their reasons for marrying, the mothers are inclined to say that *they married to get away from an unhappy home life*. 'He just happened to be the man available at the time. I was fed up with my job and fed up with nursing my mother, so I got married to escape everything.' The majority of the subjects were inclined to say that *their marriage had been frankly unhappy*. 'My husband was a beast. Just a typical man. Only interested in drink and sex. I don't think I had a happy day during the whole of my married life.' There is a tendency also for *the husband to be considerably older (at least nine years) than his wife*. In many cases the mother stated that the marriage was held together only by her feelings for her children. One of the mothers, in putting this point, made an amusing and revealing slip of the tongue. 'Thank goodness I've always had a strong material instinct.'

Talking of the physical side of their marriage, *the mothers tend to describe their sexual relations as being frankly repellent*. 'I can't stand people touching me or pawing me and I never could. Although I was fond enough of my husband at the beginning of our marriage I still couldn't stand being pawed and slobbered over.'

Finally, in speaking of her own health, *the mother is apt to say that her health has been very unsatisfactory*. During interview these subjects were apt to deluge the investigator with a flood of complaints about their own health.

Responses specifically characteristic of the neurotic group

By the same procedure it is possible to obtain the following pattern of responses which, in their frequency of occurrence, can be regarded as representative of the neurotic group.

A. *The interviewer's impressions of the mother*

Although there were some categories here in which the mothers of neurotics were more frequently represented than the subjects of the other two groups none of these reached the required level of significance.

B. *The mother's description of the patient's life history*

In speaking of the patient's infancy these mothers are more inclined to say that *the patient was an extremely attractive infant*. While the physical appearance of the infant is, of course, referred to by the mothers in the other groups, the subjects in the neurotic group tend to dwell upon the infant's physical attractiveness. 'She was lovely to look at and lovely in nature. She was just like a beautiful wee fairy. I loved to wash and dress her up like a doll.' Another distinctive feature in the reports of the neurotic patient's childhood is the suggestion of *emotional lability* which appears in many of the responses. 'Liza was the sort of child that you never knew from one moment to any other what mood she would be in. . . . She was terribly excitable and easily affected by things around her. . . . She laughed easily and cried easily. . . . I always felt that she would be happier if she could have disciplined her feelings or controlled them in some way. Liza was always so much at the mercy of things in life that didn't affect others.'

The patient's health in childhood is more likely to be described as having been poor. According to the mothers' reports there is a definite suggestion here that the childhood of the neurotic patient is disturbed by repeated illnesses. In some cases the ill health includes a specific illness of some severity which is usually seen to have had lasting effects. In the present group of twenty, four of the mothers declared that the patient had been diagnosed as suffering from some form of chorea in childhood. Where this illness occurred it became apparent during the child's school-days, somewhere between the age of six and nine years. In the majority of cases, however, the patient was

reported as having suffered from a barrage of physical illnesses with little time between them to allow the child to recover normal health. A record of a long series of illnesses is a repeated feature in the childhood of many of the neurotic patients. One patient, for example, is reported as having suffered from a severe attack of bronchitis at the age of ten months, scarlet fever at the age of three years and severe tonsillitis at the age of seven, culminating in tonsilectomy. This was followed by an attack of catarrhal jaundice which affected her heart, and six months later when the patient was eight years old she developed dysentery which was still being treated when the patient contracted diphtheria. On coming home from hospital she had to be treated for a severe attack of gastro-enteritis. Her earlier bronchial trouble developed into asthmatic attacks which began at the age of four and continued for many years. Of some interest here is the effect of the child's physical illnesses on the mother's subsequent behaviour. Many of the subjects stated that the bout of ill health to which the patient was subjected made them overprotective and overconcerned about the patient's health thereafter. This led them at times to restrict the patient's activities as they felt their child to be vulnerable and less able to stand up to things. 'After Joan had these illnesses one on top of another I felt I should keep my eye on her. I think now that it made me shield her too much and maybe protect her too much for her own good. Looking back now I can see I did all sort of things for her that she would have been better doing herself. Not only that, but I would try to do anything which would prevent her suffering in any way. Perhaps I overdid this and gave her the wrong impression of the world outside. For example, I would always change the ending of stories I told her so that nothing ever ended unhappily.'

In discussing the patient's occupation the most distinctive trend which emerges in the case of the neurotic group is that *the patient may be reported as having been dissuaded from following his own vocational preference*. This persuasion, usually on the part of the mother,

tends to be related to the patient's early illness and to the mother's opinion that the patient requires constant care and protection. Five of the female patients, for example, had at one time wished to enter the nursing profession. In all but one of these cases the patient was dissuaded from this ambition through the influence of her parents, particularly her mother.

The main distinctive characteristic of the neurotic patient's interests is that *he is more inclined to be interested in religious matters*. Such interest in religious matters was usually initiated somewhere around the adolescent period. In the seven patients who were reported to show this characteristic, all had experienced sudden religious conversion somewhere between the ages of fourteen and seventeen.

Regarding the patient's relations with the opposite sex, *he was described as having been disappointed in love*. The theme of unrequited love appears to figure frequently in the history of the neurotic patients. Not only are they frequently described as having been let down by a boy or girl friend to whom they were attached, but they appear to have reacted very intensely to such circumstances. Several of the patients had a very long history of unfortunate romances which had all culminated in disappointment and frustration. The mothers frequently commented that these experiences robbed the patient of his self-confidence and made him feel unwanted and unloved.

C. The mother's description of the patient's illness

Asked for her opinion as to the aetiology of the patient's breakdown, the mothers in this group showed a tendency to say that *the breakdown was due to early severe physical illness*. 'I don't think she really ever got over that terrible two years of illness she had when she was little. From that time on I always felt that she was less able to cope with difficulties than other children. I think that her breakdown really goes back to that very early age.' This type of comment shades into the next category of response denoting the mother's tendency to

say that *the patient's illness represents a culmination of life-long difficulties*. This is a very distinct tendency in the neurotic group, the majority of the mothers taking the point of view that the illness had a long history and that the onset was a gradual one. The patient has never been 'normal' in so far as he has always been vulnerable and shown a tendency to react in an extreme fashion to difficulties which others take in their stride. The following statement is representative of the type of comments made here. 'I don't look upon her present illness as an illness so much, but just as the ending of something I have been expecting at the back of my mind for a long time. Many of the things she is complaining about now she has had, although not in such a violent way, most of her life. If you asked me what had caused her illness I think I would have to say that it's just that she has never been able to adjust to adult life. She is much younger than her age and too gentle. She has always really been younger than her age. She's just immature.'

D. *The mother's description of her own life history*

Looking back on her own childhood the informant tends to describe herself as being *nervous and easily frightened* and she may describe *specific fears or phobias*. An interesting aspect of such phobias is that the mother's phobia is often seen to be repeated in the behaviour of the patient, and it may in some cases be related to the patient's maternal grandmother.

Speaking of her own marriage, the informant is inclined to say that *the physical side of her marriage is considered to be of minor importance and has given only limited satisfaction*. The majority of the mothers in the normal control group describe their sexual relationship with their husband as being satisfactory and as playing an important part in their marriage. The majority of the mothers in the schizophrenic group either describe the sexual side of their marriage as being frankly repellent or make remarks which indicate that their re-

lationship with their husband could be described as cold and lacking in affective interchange. In contrast to this, the majority of the mothers in the neurotic group make statements which might be described as occupying a middle position between these two extremes. While one might describe them as being sexually frigid their comments also give the impression that, outside of their sexual relationship, there existed a relatively warm relationship between husband and wife, involving a fair degree of emotional interchange.

Finally, when speaking of their own health, the mothers in this group are apt to say that *they have been rather nervous and disturbed of late because of menopausal difficulties*. They report a variety of reactions to this period of life, perhaps the most common of which is increased irritability, difficulty in sleeping, loss of appetite, tendency towards emotional outbursts, etc. Several of the mothers were under medical treatment for their difficulties and were receiving sedatives from their medical practitioners.

SUMMARY AND CONCLUSIONS

In the early history of both the neurotic and schizophrenic patient we find a great deal of common ground. The frequency of such traits as obsessional behaviour, nervous symptoms, lack of self confidence and self assertion, over-dependency on the mother and a general inability to reach an adequate level of adjustment to the social group differentiates both sets of patients from their non-patient peers. The degree of social inadequacy is seen to be more persistent and to pervade more areas of the patients' lives in the case of the future schizophrenics, but the main difference between the two groups is to be seen in the mother's interpretation of, and reaction to, the patient's deviant behaviour. In the neurotic group the mother displays a more rational and insightful attitude to her child's difficulties. She in fact recognizes that the behaviour is deviant and does her best, usually unsuccessfully, to aid the

patient in making a more stable adjustment. The mother of the schizophrenic patient shows, on the other hand, a remarkable capacity for denial in her attitude to the patient's earlier difficulties. Not only does she distort reality in projecting the cause of the patient's abnormal reactions outside of him, but she also accepts, approves, and actively encourages the deviant features in his development. Her influence on the patient is almost specifically designed effectively to cripple the child's attempts to reach an independent and stable level of adjustment. The mother's irrational interpretation of events, her lack of adherence to logic and her manipulative attitude to others is strongly evident in her attitude and behaviour in the present interview situation. Such impressions are in accordance with the observations reported in previous studies which have commonly stressed the dominating, egocentric and manipulative role of the mother who is unable to form 'a proper respect for the individual's need to be himself and an acceptance of him in his own right' (Reichard & Tillman, 1950).

It would seem doubtful, however, whether the oft-used term 'overprotective' can be validly applied to the pattern of child rearing in schizophrenia. From the observations of the present study one might almost argue that 'overprotection' is more typical of the early background of the neurotic than that of the schizophrenic. The overprotective attitude is stimulated by the frequency of childhood illness which figures so prominently in the early history of the neurotic patient. These early events tend to cause the mother to regard the child as being in special need of care and protection, thus originating a degree of maternal concern which continues to exert its influence throughout the patient's life. This suggestion of a low degree of resistance to illness in the neurotic's childhood has been observed in previous sociological studies (e.g. Slater & Woodside, 1951). Previous evidence has indicated that, not only do neurotics suffer from a higher proportion of illnesses in childhood, but that their illnesses lead to further compli-

cations much more frequently than the non-neurotic population. The mothers in the present study describe the neurotic patient as being vulnerable, not only physically but emotionally as well. He is seen to be more at the mercy of his environment than others and therefore more in need of a well protected and regulated existence.

The frequency of marital disharmony in the home of schizophrenic patients is clearly evident in the interview responses and is in accordance with previous findings. The most common criticism made by the mothers in the present study regarding the patient's father is that he is of a weak character, lacking in 'masculine' forcefulness and ambition. It is of interest to note that the mother tends to level exactly the same criticism at her own father. Bearing in mind also the abnormal attitudes to sex expressed by these mothers, one might interpret the findings as suggesting a basic inability to accept the female role. At any rate, the object choice of the mother tends to be an individual who, in his passiveness and acceptance of feminine domination, is allied in nature to her own father. This suggestion is given further support by the observation that the mother frequently marries a man some years her senior.

Our observations also allow us to consider the view that the mother-child relationship in schizophrenia is abnormal only because of the aberrant behaviour of the schizophrenic from childhood onwards. The present data do not bear out the contention that the mother in some way senses the 'inferiority' of the child who later becomes schizophrenic. On the contrary, their reports show an astounding lack of insight, and often complete denial, in respect of the patient's abnormalities. They see the schizophrenic symptoms as appearing suddenly without warning in a previously normal personality. The present evidence points more to the neurotic patient as the one whose constitutional inferiority is recognized early by the mother, who is not surprised by the final breakdown. A further answer to our question is to be found in the picture which

emerges of the mother's own life history prior to the patient's birth. The material here shows a characteristic pattern which is almost specific to the schizophrenic mothers. These women tend to report an unhappy early home life which is often disrupted further by parental loss. As children they are unhappy, insecure and unable to make good contact with others. They remain to some extent social isolates throughout their lives, their marriages predestined to failure by their rejection of their own femininity. Perhaps the most characteristic feature of these women is the already mentioned capacity for denial and distortion which so colours their unrealistic interpretation of events. In their attitude to their children one is impressed by their lack of acceptance of the child's individuality and by the degree to which their influence draws the patient into the mother's orbit of egocentricity.

In a second paper (McGhie, 1961) an attempt will be made to collate the interview

findings with the information given by the personality tests and to relate the whole to the question of schizophrenic aetiology. We can say at this point, however, that the interview findings agree to a large extent with the observations made by many of the previous investigators in this field. Interestingly enough, it would appear that these findings most closely approach the descriptive account of the mothers of schizophrenics made by Lewis Hill on the frankly subjective basis of his own experiences with schizophrenic patients and their families.

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A comparative study of the mother-child relationship in schizophrenia

II. Psychological testing

By ANDREW MCGHIE*

In a previous paper (McGhie, 1961), the author reported some of the findings of an investigation testing the validity of the hypothesis that mothers of schizophrenic patients tend to exert a pathological influence on their schizophrenic offspring. This investigation took the form of a comparative study of mothers of schizophrenics, neurotics and normal subjects who were each examined over a series of six 90-minute sessions by means of a standard interview technique and a battery of personality tests. A total of 60 mothers, 20 in each of the three groups, was studied in this way. Although the numbers are thus relatively small, it was felt that the amount of time which it was possible to spend with each subject amply compensated for the more statistically acceptable, but less reliable, information which a larger, more superficial study might yield. The earlier report dealt only with the analysis of the interview material and the resultant pattern of responses which was seen to be characteristic of each of the two patient groups. In the present paper the test findings will be described and discussed in relation to the picture of the subjects which emerged from the interview material. Finally, an attempt will be made to discuss the significance of the conclusions of the study as a whole for the aetiology and development of the schizophrenic condition.

While a detailed analysis of the interview was given in the first report on this study, it is perhaps worth while briefly to recapitulate in outline the patterns of responses which were considered characteristic of each of the two patient groups.

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(1) Interview responses characteristic of mothers of schizophrenic patients

The mother tends to impress one as being ambivalent and manipulative in her attitude to the interview situation. She may admit that she has been disturbed in her health at a time coincident with the interviewing period. Often her speech is spontaneous in form but irrelevant and incomprehensible in content. Her flow of speech tends to dominate the pattern of the conversation.

Her description of the patient's infancy contains no characteristics which are in any way specific to her group. One exception to this is that the mother tends to have great difficulty in remembering when toilet training was initiated or completed. Asked about the patient's school days she may say that she had some initial trouble with the patient when he first started school. This is also reported in the case of the neurotic patients, but the mother of the schizophrenic patient is more likely to comment that this initial difficulty continued throughout the patient's later schooling. His work record after leaving school and prior to the onset of his illness is likely to be poor and erratic. Although there is nothing unique in the patient's interests, his range of interests is inclined to be very narrow and limited. In comparing the patient with his siblings the mother is inclined to describe him as being quieter and in various ways more dependent than his brothers and sisters. In his relations with his parents he may be described as showing little affection to them. In such cases the mother is inclined to add that she herself is undemonstrative and that she has difficulty in displaying affection towards her children. In his relations with others outside of the family circle he is likely to be described as taking a

very submissive role. It is likely that the mother will say that the patient has shown no interest in the opposite sex and to declare that she approves of this lack of interest.

Speaking of the patient's illness the mother is apt to regard the patient as having been 'normal' until the onset of his illness. The mother is inclined to put the cause of the illness down to either loneliness caused by the patient being away from home, or to a variety of sexual matters.

In speaking of herself and her own life the mother may say that her childhood was marred by the loss of one of her parents. This may be due either to death of one parent or to the parents being separated or divorced. Describing her own father she is inclined to say that he had a very weak character or that he was unapproachable and distant in his manner. Looking back over her own childhood she tends to feel that she was always sensitive and shy. She describes her childhood on the whole as being an unhappy one. Where she has worked outside of the home she is likely to express regret at not having continued her career which was broken by marriage. Speaking of her relations with others during her earlier adult life she is inclined to say that she has never enjoyed company, has had a limited social life and invariably prefers to be alone. During her married life her interests have centred narrowly on the family and she has very little social life outside of the home. She may say that she was always particularly shy with boys and it is very likely that her husband will be described as her first and only boy friend. In describing her husband she is apt to criticize him for avoiding responsibility in the home. She may also complain that he is lacking in ambition and drive. Her husband is more likely to be at least nine years older than the informant. In speaking of her marriage she may admit that she married her husband in order to get away from an unhappy home life. Summing up the marriage as a whole she is inclined to say that it has been an unhappy one and there is a tendency for the marriage to have actually broken up through separation or

divorce. Her sexual relationship with her husband in marriage is unlikely to be a satisfactory one and she is inclined to describe the sexual side of her marriage as being frankly repellent.

(2) *Interview responses characteristic of the mothers of neurotic patients*

The mother is inclined to describe her child as having been a particularly attractive infant. As a child he is frequently described as having been emotionally labile. His physical health during childhood is likely to have been poor. Of his progress at school the mother is apt to describe him as being very conscientious and easily worried about examinations. She may say, however, that he was the most intelligent child in the family. He is more likely to have continued with further education on leaving school and there is a tendency for the neurotic patient to be still engaged in some form of study at the time of interview. Where the patient is actually engaged in an occupation, his mother may report that he was dissuaded by his parents from following his own vocational choice. His interests are distinguished from those of the other groups by his being particularly interested in religious matters. Speaking of his relations with the opposite sex, his mother is apt to comment that the patient was repeatedly disappointed in love.

The mother may consider that the patient's illness has been directly due to early severe physical illness and on the whole she is inclined to take the view that his illness is a culmination of lifelong difficulties. She regards the onset of the illness as being a very gradual process.

Of her own childhood the mother is inclined to say that she was nervous and easily frightened, and she may mention a number of specific fears or phobias to which she was subject. In speaking of her marriage she is likely to imply that her sexual relationship with her husband has given her only limited satisfaction and is regarded as being a factor of minor importance in their marriage. Speaking

of her own health she may describe various difficulties which have been apparent during the involutional period.

THE PSYCHOLOGICAL TESTS

The interviews were conducted during the third and fourth sessions, the first two sessions being entirely devoted to establishing a good relationship with the subject and allaying any indications of defensive anxiety. The tests, which were performed during the last two sessions, were as follows:

(1) *Child-Rearing Questionnaire*

A questionnaire was compiled containing a total of 40 statements dealing with various aspects of child rearing. The majority of these statements were taken from the questionnaire used by Marks (1953) in his comparison between the responses of mothers of schizophrenics with mothers of normal adults. Marks found in his investigation that such a questionnaire clearly differentiated between his two groups. The inclusion of the questionnaire in the present investigation offers an opportunity of assessing the differential significance of the items where the schizophrenic mothers' responses can be compared, not only with a normal control group but with a second patient group of mothers of neurotics.

(2) *Sentence Completion Test*

The test consisted of a total of 43 items, each consisting of an incomplete sentence. This form of test has been used a great deal in psychological research, and the items comprising the present test were based on the version first used by Rotter & Willerman (1947) and later developed by other workers. The subjects were presented orally with each item and asked to complete the sentence as rapidly as possible.

(3) *Word Connexion List*

It was thought necessary to include a test which might give some discrimination between the relative degree of mental stability of the

three groups. Probably the best validated test of this type is the Maudsley Medical Questionnaire which had been shown to discriminate at a high level of significance between normal, neurotic and psychotic groups. Although this test was included in the preliminary stages of the investigation, it had to be abandoned, mainly because of the obvious and self revealing nature of the majority of the items. When presented with the test the patient groups in particular were apt to react with anxiety or hostility to this obvious assessment of their mental state. For this reason the Word-Connexion List (Crown, 1952) was used to the same purpose. This test has also been the subject of many validation studies although its validity is not as firmly established as that of the Maudsley Questionnaire.

(4) *Rorschach Test*

It was hoped that this projective test might provide a method of comparing the personality profiles of the subjects in the three groups. The test was administered to each subject individually and scored according to the system given by Klopfer, Ainsworth, Klopfer & Holt (1954).

Results of testing

(1) *Child-Rearing Questionnaire*

Taking the cumulative score on this test to be the total number of agreements to the 40 statements presented, the questionnaire successfully differentiates the schizophrenic group from both the control and neurotic groups, the difference between the means ($S = 20.95$, $C = 11.55$, $N = 10.40$) being significant above the 0.01 level. Marks (1953) applied an extended form of this questionnaire, containing 139 items, to mothers of male schizophrenics and normal controls. The shorter version of the questionnaire used in the present study contains most of the items which Marks found to be significant. The performance of the subjects in the present investigation thus indicates that a questionnaire of this type successfully differentiates the mothers of schizophrenics not only from the normal

control group, but also from the mothers of neurotic patients.

In order to obtain some idea as to the particular items in the questionnaire which accounted for the difference in group scores an item analysis of the test was carried out. The procedure here was to construct contingency tables of the items which appear on inspection to separate the three groups. In subjecting the individual items of a questionnaire to a χ^2 -analysis, certain difficulties arise in assessing the significances which are determined. One of the main problems here has been clearly outlined by Cronbach (1949) in his criticisms of the statistical methods normally applied to Rorschach scores. Referring to what he terms the 'Inflation of Probabilities', Cronbach points out that, where a number of items are being tested for significance, the total number of significant tests must be taken into account in evaluating their probability. This point may be equally validly applied to any other tests, such as the present questionnaire, which involved significance tests for the forty items. Although actual testing has been carried out only for those items which suggest on inspection significant differences, we must also take into account the other items which have been rejected after inspection. Using the conventional 5 % significance, we should expect that in a test containing forty items, two items would significantly differentiate the groups by chance alone. In view of this point, it was decided in the present study to accept as significant only those items which were at the 2 % level or above. This does not provide an entirely satisfactory answer to the problem, but by raising the standards of acceptance in this way we might hope to isolate only those items where the significance is meaningful.

There are in all, a total of 11 items which significantly differentiate the schizophrenic group from both the normal controls and neurotic group. The mothers of schizophrenia patients are more inclined to agree with the following statements:

1. The young child should be protected from hearing about sex.

2. Children should be taken to and from school until the age of eight, just to make sure there are no accidents.

3. Children who take part in sex play may become sex criminals when they grow up.

4. A child should not plan to enter an occupation of which his parents do not approve.

5. Too much affection will make a child a 'softie'.

6. It is not the duty of parents to teach the child about sex.

7. A good mother should shelter her child from life's little difficulties.

8. If children are to grow up and get somewhere, they must be continuously kept after.

9. It is best to give children the idea that their parents have no faults.

10. Children who always obey grow up to be the best adults.

11. The father's influence on a child's life is of little importance in comparison with the influence exerted by the mother.

The trend of these significant items is in accordance with the observations of these mothers already made during interview, reflecting a general tendency towards over-restrictive control and a preoccupation with the adverse effects of sex. It is of interest to note that only in the case of the schizophrenic group do the scores reach a level which isolates this group from the others. In not one case does this occur in the neurotic group, whose responses correspond closely with those of the normal controls.

(2) *Sentence Completion Test*

Examination of the responses to this test supports the claim that the test yields useful information on the personality attributes of individual subjects. When each subject's responses were compared with the interview record it was evident that the test results supported, and at times added to, the information obtained directly from the subject during interview. When we move from individual to group comparison, however, difficulties in handling the comparative data become im-

mediately obvious. The test items cover so many personality variables as to defeat any attempt at systematic and objective comparison. As the test has been often used as a research instrument, a number of attempts have been made to introduce a system of scoring which overrides such difficulties. Perhaps the most satisfactory and best validated of these scoring systems is the one introduced by Rotter & Willerman (1947) and later used successfully by Rotter, Rafferty & Schachtits (1949), Rotter & Lotsof (1950), Hadley & Kennedy (1949). The method here is to rate each response on a seven point scale, according to the degree of mental stability denoted by the response. The rating continuum runs between conflict (+3, +2, +1) and healthy (-3, -2, -1) with neutral (0) responses occupying an intermediary position. Rotter gives characteristic examples of different rating values for each item which act as a guide to scoring. The subject's final score is, of course, the algebraic sum of the ratings on the forty-three items of the test. It will be readily apparent that this procedure is not entirely adequate and that it certainly leaves a great deal of room for subjective distortion in scoring. It does, however, have the merit of concentrating on one variable only and its reliability is reported as being higher than one might suppose. Before scoring the test material in the present study, the responses were transferred to separate cards, one for each of the forty-three test items. The responses of the sixty subjects were then rated together, item by item without any identification as to which group or individual the response belonged. It was hoped, by this means, to keep subjective influences down to a minimum. An examination of the final group mean scores ($S = +15.20$, $C = -10.70$, $N = +4.15$) shows that the normal group tend to return definitely negative ('health') scores, the schizophrenic positive ('unhealth') scores, with the neurotic group adopting roughly an intermediary position. The difference between the means is significant for both patient groups in comparison with the normal controls, but the

mean scores also differentiate between the schizophrenic and neurotic groups.

Rotter's method of scoring provides us with a useful method of comparing the responses of the three groups in respect of one broad variable. For the purposes of the present investigation it is very helpful to use the scores obtained to conduct an item analysis of the test in the same manner as we have dealt with the previous tests. In so doing, we extend our information to allow some indication as to which of the test items account for the greatest differences in scoring among the three groups. The most direct method of conducting an item analysis on the basis of the test scores is to calculate the total score per item for each of the three groups in turn, and to use these figures to construct contingency tables. It was felt, however, that as the scores in this case are ratings which are more open to subjective contamination this method might give misleading results. One of the main difficulties is that a cumulative group score for each item would tend to give too much weighting to 'neutral' scores which in many cases refer to responses which are completely lacking in any degree of personal significance. In view of this, it was decided to use an alternative procedure which places less emphasis on the seven point scoring system, concentrating only on positive scores of any value. Taking each test item in turn, a note was made of the number of subjects in each group who returned positive ('unhealth' scores), regardless of differences in the numerical order (+1, +2, +3) of the scores. Items which, on inspection, appear to indicate significant differences between group responses were tested by the usual contingency tables. It is not possible here to consider the implications behind the responses which account for the quantitative difference in group scores. In general, however, such an examination yields a distinct trend which is in accordance with the other findings in this study. The responses of the neurotic group seem to typify the subject's recognition of her own personal inadequacy and reduced capacity to cope with life. In the responses of the

schizophrenic group, one can also discern personal inadequacy which is, however, characteristically projected outwards in an almost paranoid manner. Again evident in this group is the openly aggressive attitude to the male sex.

(3) *Word Connexion List*

This test was used as an alternative to the Maudsley Medical Questionnaire to give some overall indication of the relative mental stability of the three groups. The mean scores here ($S = 12.85$, $C = 11.54$, $N = 17.30$) significantly differentiate the neurotic group from both the normal controls and the schizophrenic group. The results of this test are thus in contrast to the results obtained on the Sentence Completion Test where the scoring system applied is also described as providing an index on mental stability. The most obvious explanation here is that, although the two tests set out to measure the same broad variable, they do so in quite different ways. The Word Connexion List demands only the choice of two alternative responses, the significance of one of these being often rather obvious. In fact, several of the schizophrenic group subjects declared spontaneously that it was easy to select the 'right word' from the two alternatives. In other words, the form which this test takes makes it a very simple matter to perform defensively and provide a more 'stable' total score than might otherwise result. In the case of the Sentence Completion Test the procedure is less structured and, if the subjects conform to the instructions regarding speed of responses, less open to defensive deliberation. Of these two tests, it seems likely that the Word Connexion List provides a more direct measure of neuroticism, whereas the Sentence Completion Test provides an assessment of the deviant attitudes expressed by any group. Our previous examination of the form which these deviant attitudes take would suggest that the instability in the schizophrenic group lies in a basic egocentricity and an inability to establish positive, mature, interpersonal relations. In the case of the neurotic

group, the basic disturbance might be conceptualized as representing more a recognition of personal inadequacy and inferiority. The contrast between the two groups in this respect will perhaps be made clearer in our consideration of the final personality test in the present battery—the Rorschach Test.

(4) *The Rorschach Test*

In using the Rorschach Test as a research instrument one is inevitably faced with the restrictions imposed by the absence of any completely adequate method of comparing group scores, for example the fact that the total number of responses returned by different subjects may vary quite widely alters the probability of any particular category of response being present in the record. Another difficulty lies in the fact that, while most of the Rorschach categories can be expressed numerically (usually in the form of a percentage of the total number of responses), there are others (e.g. colour shock, confabulation, etc.) which are indicated only by their presence or absence in any record. The varied statistical procedures which have been applied to the Rorschach Test by research investigators have been strongly criticized by Cronbach (1949) in a paper to which we have already referred. The disadvantages of the traditional method of comparing the mean group scores for each of the Rorschach response categories have been thoroughly exposed by Cronbach and need no elaboration here. Cronbach suggests that a less objectionable alternative statistical procedure here is to arrange all the scoring categories in such a manner that a χ^2 -analysis can be applied. It is further suggested that the analysis should be directed in such a way as to answer a number of specific hypotheses regarding group differences on the different Rorschach scoring categories. Thus, rather than comparing the three groups on the basis of, say, percentage of animal content ($A\%$), the procedure here would be to compare the number of subjects in each group with a high $A\%$ (i.e. above a pre-established 'normal' level).

This method of analysis has the added ad-

vantage in that it overcomes the difficulty of introducing the Rorschach signs which cannot normally be expressed as percentages or as quantitative scores.

The analysis of the scores was restricted to those lying outside of normal limits, these limits being established prior to the actual analysis by reference to Klopfer *et al.* (1954). In establishing the significance of the various items, we are, however, again faced with the problem of inflated probabilities by applying χ^2 -tests to a large number of scoring categories within the same test. Although only twenty-six scoring categories were actually considered, it is almost impossible to estimate the number of categories which have been rejected by implication. However, the problem is perhaps less acute here as compared with the previous test in the battery. The majority of the twenty-six scoring categories considered were selected on the basis of the investigator's own hypothesis that the Rorschach Test might show group differences in a predictable direction. On the basis of the information already gained from the interview material and the other tests in the present battery it seemed possible that the schizophrenic group might show a basically schizoid element in their responses while the neurotic group might show a pattern indicative of a general neurotic emotional instability. Our purpose here was to test a specific pre-established hypothesis and to some extent this frees us from the objections levelled at this from critical χ^2 -tests. In view of this, items acquiring the probability of 5% or over have been accepted for this test.

The following responses appear to be uniquely characteristic of the schizophrenic group—a high $F\%$, shading responses dominating colour responses, a low $W\%$, high $Dd+S\%$, presence of confabulation and contamination, personal references and morbid and bizarre content. Let us attempt to examine this pattern on the basis of the usual Rorschach interpretations. The disruption of form level represented by the higher $F\%$ suggests a lack of control and inadequate contact with reality. This tendency to distort

reality is again evident in the relative preponderance of confabulation, contamination and the higher number of morbid and bizarre responses which appear in this group. A deficiency in abstract thinking and a tendency towards concrete perception is indicated by the low $W\%$ and the tendency towards personal identification with the blots. The high $Dd+S\%$ is achieved mainly through an increase in the number of white space responses given, and might thus be interpreted as representing an obsessional and negative attitude towards the environment. Finally, the predominance of shading over colour responses implies a degree of restriction of the subject's emotional contact with her environment.

The responses uniquely characteristic of the neurotic group are as follows— $CF+C$ responses outnumbering FC responses, high $A\%$, high number of K or k responses, colour shock, and an increase in the number of means rejected. One might interpret this pattern as suggesting a degree of immaturity, a lack of normal mature emotional inhibition and resulting inner anxiety.

It would appear, indeed, that our original hypothesis has been to a great extent verified. The pattern characteristic of the mothers of schizophrenics corresponds to a diluted version of the typical Rorschach pattern given by schizophrenic patients. Similarly, the characteristic pattern of the mothers of neurotics is indicative of neurotic disturbance and is in fact not atypical of the pattern which one expects from patients with hysterical tendencies. This finding as applied to the schizophrenic group has been noted by previous investigators. Müller (1950) applied the Rorschach Test to forty schizophrenic parents and found that a number of them, although clinically normal, showed evidence in their test responses of severe character disturbance in the direction of schizophrenia. Modonesi (1951) made a similar finding after giving the Rorschach Test to ten relatives of schizophrenic patients. It is thus of some interest that a consideration of the responses which identified the two patient groups leads us to the conclusion that the

behaviour of these mothers on the Rorschach Test corresponds to a great extent with the performance one might expect to be given by their schizophrenic or neurotic offspring.

SUMMARY AND CONCLUSIONS

Before finally reviewing the findings of the present study and allowing ourselves to speculate upon their bearing on the aetiology of the schizophrenic condition, it is perhaps as well to mention a few obvious limitations. The arguments in favour of using comparatively small groups in an investigation of this type have already been discussed.

The size of the samples involved, however, does limit the scope of the inquiry and prevent the investigation of inter-group differences which would be more readily examined in a larger scale project. No attempt, for example, has been made to compare the respective attitudes of the mothers to male and female schizophrenic offspring. Our data suggest that the psychopathology of these women is such that their reaction to a male offspring would be the more intense and destructive, but the numbers involved here do not make a systematic comparison possible.

In the present study the father's role has only been seen indirectly, through the eyes of the mother. A number of the fathers in the schizophrenic group were seen separately during the course of the interview, although this was incidental to the main study. One's impression of these fathers was that they conformed closely to the picture of the submissive, emasculated male drawn by their wives. In a few cases the father struck one as being not so much submissive as disinterested in his role in the home. Other investigators (Lidz, Parker & Cornelison, 1956; Lidz, Cornelison, Fleck & Terry, 1957; Bowen, Dysinger & Basamania, 1959) who have made a direct study of the paternal role in schizophrenia, have also laid emphasis on the negative role played by the father. Myers (1956), in a factorial study of the schizophrenic's family history, found the absence of a strong paternal

figure to be one of the most constant features involved. If the schizophrenic is to be regarded as in any way a product of his familial environment, then the father's role is obviously of great importance. As interest in the present study has been primarily directed to the maternal role, we have tended to limit his significance to a reflexion of the mother's object choice.

Apart from the case of only children, the family unit is not, of course, restricted to the triangle of parents and the schizophrenic offspring. The impact of parental attitudes upon the development of the schizophrenic cannot be fully assessed unless we take into account the siblings who, though reared by the same parents, do not become schizophrenic. It may, of course, be argued that, as each human relationship is a unique one, the maternal influence may vary greatly, both in its form and intensity, and that the pathological mother-child relationship is specific only to the schizophrenic patient. This argument is, however, far from convincing and there is an obvious gap in our information which is also apparent in previous investigations. Again, during the course of this study, contact was made with a number of siblings of the schizophrenic patients. In some cases these siblings themselves made contact with the express purpose of spontaneously relating the effect of the mother's behaviour on the patient's eventual breakdown. From the reports given in the present study it would seem, however, likely that most of the siblings had survived their early rearing to have made a reasonably normal and stable adjustment to adult life. We will shortly return to the implications of such circumstances in attempting to assess the effect of the mother-child relationship on the aetiology of schizophrenia. At present it is only meant to draw attention to the need for a corresponding comparative study of the siblings of schizophrenic patients.

Bearing in mind these and other limitations inherent in the present study we might briefly summarize the main findings as follows:

The basic hypothesis that the mothers of

schizophrenic patients display a uniform pattern of personality traits, which is not evident in mothers of normals or neurotics, has been largely verified. The features composing this characteristic pattern are mainly those which have been observed in previous studies of a similar nature. After an unhappy and insecure childhood, frequently aggravated by parental loss, they show a repeated failure to make an adequate social adjustment. The relationships they do form with others are coloured by their need to manipulate others in accordance with their basic egocentric needs. Their object choice in marriage is that of a weak and submissive male, resembling their own father, who, unless he remains detached from family events, is quickly and effectively emasculated. The failure of the marriage is determined further by the mother's intense preoccupation with, and abhorrence of, all forms of sexual activity. The children of the marriage, while apparently accepted and adequately cared for in infancy, are soon exposed to the influence of a dominant mother whose behaviour towards them is effectively designed to isolate them from others and establish a continuing dependency on her. This curious combination of emotional detachment and mothering devotion results in an asymbiotic relationship of such intensity that we can appreciate Hill's comment: 'What is a schizophrenic profited if he shall gain the whole world and lose his own mother' (Hill, 1955). Perhaps the most outstanding feature, which appears in all aspects of their behaviour, is the mother's capacity to project, deny, rationalize and distort reality to suit her own needs. Rather than adjust to the external world she adjusts the external world to her at the expense of an adequate relationship to reality. This aspect of the mother's behaviour is clearly evident in face to face contact during interview and in her response to personality testing. It is perhaps most clearly demonstrated in the Rorschach Test where her performance contains a mixture of thought disorder and reality distortion which resembles a 'diluted' schizophrenic performance.

Having established the presence and form of pathological features in the maternal relationship we are faced with the more difficult problem of relating such factors to the aetiology of schizophrenia.

'The basis of sanity is correct and automatic recognition of the breach between subjective mental individual experience in the world and the knowledge of the status of the world as it actually exists. . . . It is therefore obvious that in schizophrenia it is the ego that is ill' (Federn, 1953). Federn's description of schizophrenia as being basically a disturbance of ego functions and a failure of adjustment to reality would be generally accepted even by those who deny the importance of environmental experience to the development of schizophrenia. In order to assess the possible effects of a pathological mother-child relationship on the ego functions let us first refer briefly to the course of normal ego development. The work of Piaget (1929, 1930, 1932, 1951) and other authorities on child behaviour has demonstrated that adjustment to reality is not fully attained until late childhood. During the 'adualistic' stage of infancy there is no differentiation between the self and the outside world, no self awareness and no consciousness of external objects. Even in early childhood, when the child has become a fully conscious being, his thinking is still essentially egocentric and limited by the incomplete differentiation between the self and the external world. The child's interpretation of the world around him differs from that of the normal adult in that he 'does not conform to reality but rather deforms reality moulding or "assimilating" it into something which subjectively concerns him, rather than adapting or "accommodating" himself to it' (Freeman & McGhie, 1957). It is only after a long process of trial and error that he adjusts to objective reality as it is and becomes capable of reality-adapted thought and action. Out of this process of differentiation between external reality and inner mentality emerges the 'self' as an object distinct from all other objects. Equipped with the basic differentiation of the self as a figure apart from the background of

environment, the child is able to acquire other differentiations which are functions of the healthy ego. Of perhaps prime importance among such functions is the ego's ability to select from the background of past apperceptions only those which are pertinent and applicable to dealing with a reality situation in the present. This function of reality testing, what Linn has appropriately termed the 'scanning' operation, is described more fully in Bellak's theoretical paper on the psychoanalytic concept of the ego as related to schizophrenia. 'Thus...the ego selects and organises these apperceptions which are conscious or can easily become conscious and which are continuously part of the contemporary apperception in a way which permits one to differentiate...various figure and ground judgements, e.g. external versus internal, and permits one generally to exercise "good judgement" founded upon past experience as to what is safe and what is not, what is probable and what is not...This world slowly evolves adaptively into the clearly perceived, logically related one of normal adult behaviour' (Bellak, 1958). These ego functions, which permit the normal adult to keep a firm grip on reality, do not, however, develop in a vacuum but through the individual's interpersonal reactions with others in his environment. In childhood the main media of influence is that of the parents upon whose example the child builds his own frame of reference for interpreting and dealing with reality.

Relating such aspects of normal ego development to what we know of the family background of the schizophrenic we might make a hypothetical reconstruction of the possible role which the mother's influence may play. As far as our observations indicate, the mother's care for the child in early infancy is adequate and within normal limits. The maternal attitude appears, however, to undergo a pathological change as soon as the child attempts to take his first steps in the direction of learning to become a separate individual with a will of his own. By a constant series of manipulations the mother continues effectively to prevent the

growing child establishing adequate object relations and a mature adjustment to reality. Apart from the direct effect of the mother's denial of the child's individuality, the ego development of the schizophrenic may also be crippled by constant exposure to a paralogical system of thinking which subordinates objective reality to subjective needs. If in the course of one interview these women are capable of creating an almost tangible atmosphere of confusion, one would suppose that reality testing might be severely impaired. This view of schizophrenia as a breakdown in communication due to parental distortions in the communication process has been expressed before, notably by Lidz, Cornelison, Terry & Fleck (1958) who have examined this process of 'transmission of irrationality' in schizophrenic families. After an intensive three-year study of fifteen families containing a schizophrenic offspring, the authors came to the following basic conclusion: '...the schizophrenic patient is more prone to withdraw through distortion of his symbolization of reality than other patients, because his foundation in reality testing is precarious, having been raised amidst irrationality and chronically exposed to intrafamilial communications that distort and deny what should be the obvious interpretation of the environment, including the recognition and understanding of impulses and the affective behaviour of members of the family' (Lidz *et al.* 1958). On such lines a purely environmental hypothesis may be constructed, stressing not the specific infantile trauma caused by a 'schizophrenogenic' or 'perverse' mother suggested by Rosen (1953), but the continual pattern of stress imposed by abnormal familial relationships throughout childhood and adolescence.

This is one way of interpreting the evidence of pathological maternal behaviour but the finding may be also interpreted as pointing to an entirely different, indeed an opposite, view of the aetiology of schizophrenia. The bizarre personality pattern which is so evident in the mothers of schizophrenic patients may be taken as suggesting that the process of trans-

mission is not environmental but genetic. The investigations of Kallman (1946, 1947, 1948, 1953), Slater (1953), Gardner & Stephens (1949), Wittermanns & Schultz (1950), and others argue strongly for the existence of a genetic basis to schizophrenia. Might it not then be equally reasonable to conclude that the present findings, along with those of previous investigations, merely add to the evidence of a genetic strain in schizophrenia? On consideration, such an interpretation would seem, however, to be as oversimplified and misleading as the other extreme view of a purely environmental mode of transmission. One would surely expect that exposure to such an abnormal and ego-restrictive pattern of rearing would have disastrous effects on any individual's development. Kallmann himself, while in no doubt as to the existence of a genetic substrate in schizophrenia, is careful to add that 'the final outcome of the disease is the result of intricate interactions of varying genetic and environmental influences'.

In fact, the two views expressed here are not inconsistent with each other. If we accept that the schizophrenic condition is fundamentally a disorganization of the ego we are still faced with the question as to the cause of its disorganization. Although the development of a healthy ego which allows complete self differentiation is undoubtedly influenced by the individual's interactions with others in his interpersonal environment, it is equally clear that an adequate biological substrate must also exist for the necessary development to take place. One might then conclude that, developmentally, the ego functions may be impaired, either by inadequate functioning of the biological substrate or by unfavourable influences in the environmental forces to which we are subjected at any stage of development. The origin of inadequate ego functioning thus lies in the psychobiological development of the individual and is most likely to be due to an interaction of both organic and psychological factors. The schizophrenic, we might suggest, is then predisposed towards inadequate ego development by a genetic or constitutional

weakness. His already precarious hold on to reality is further loosened by the forces in the family which actively discourage his attempts to come to terms with himself and his environment. As is the case with other aspects of mental development such as intelligence, inheritance sets the limits of the individual's capacity for development and upon his environmental experience will depend the degree to which these capacities or incapacities will actually be realized. This interpretation also offers an explanation for one of the problems which is otherwise difficult to reconcile with a purely environmental explanation of the effects of the mother-child relationship in schizophrenia. We refer here to the existence of a sibling or siblings who survive the familial influences to emerge, if not unscathed, certainly non-schizophrenic. In such cases we would hypothesize that these siblings lacked the constitutional predisposition that renders the schizophrenic offspring so vulnerable to maternal pressures.

The study finally raises many questions which, if answered, would greatly clarify the whole question of the relation between childhood development and adult illness. A number of these questions have already been introduced. A larger scale investigation built on similar lines but involving larger groups would have obvious advantages, particularly in assessing the sex differences in the backgrounds of male and female schizophrenics. Our understanding of the father's role in the family pattern is still obscure and there is an obvious need for studies of non-schizophrenic siblings. (The latter issue is to be the subject of a proposed project to be initiated soon at the Psychiatric Division of the National Institute of Mental Health, Bethesda, under Dr H. Pollin.) A study of schizophrenic patients who had been adopted and raised from infancy by step-parents would also provide a method of comparing the genetic and environmental media of transmission. Finally, in the field of child psychiatry, it might be possible to study family patterns at an early state to assess the value of existing observations in predicting the

The schizoid problem, regression, and the struggle to preserve an ego

By H. GUNTRIP*

REGRESSIVE PHENOMENA

A number of years ago I had a patient, a professional man in the forties, who in his own view presented only one symptom. He was embarrassingly preoccupied with breasts and felt compelled to look at every woman he passed. He regarded his shy and introverted make-up as simply natural. 'I'm not naturally a good mixer, not one of the sociable sort.' He felt that his preoccupation had something to do with the fact that his wife was an extremely cold and unresponsive woman, as also had been his mother, whom he always thought of as 'buttoned up tight to the neck'. This preoccupation with breasts appeared to be a regressive symptom and went along with a number of childish feelings which he intensely disliked admitting. As analysis proceeded his dwelling on breasts diminished markedly, but its place was taken by a spate of phantasies, all of the same type, in which his interest was intense. They went on for a number of weeks, gathering force and competing seriously with his professional work in the daytime. The general theme, embroidered by endless variations, was that he would retire to an isolated part of the country on the sea coast, and there build a strong house and wall it off from the busy inland life. No one was allowed to enter his domain and those who tried to break in by force were miraculously kept at bay. As contrasted with his professional and social life, his inner mental life constituted a house of that kind inside which he lived apart, and into which no one from the outside was ever genuinely admitted.

The series came to a head with a tremendous

phantasy of building an impregnable castle on top of a breast-shaped mountain, walling it round with impassable defences, and taking up residence inside. The authorities camped round about and tried to storm his citadel but were quite unable to break in. He clearly felt some uneasiness about this 'safe inside' position, did not wish to be a totally self-made prisoner, and arranged to emerge at times in disguise to inspect the outer world, but no one could get in to contact him. Finally he saw me coming up the mountain side, hurled great boulders at me and drove me off. The phantasy shows some evidence of a wish for a position of security at the breast, in conformity with his symptom, but, like the phantasies that preceded it, the real theme is retreat to a 'safe inside' situation. In this phantasy he oscillates between a breast he can leave and return to, and a womb he can get safe inside. A week or two later he suddenly broke off analysis, using a passing illness of his wife as a reason. The phantasies and the analysis had revealed the powerful regressive drive that underlay his general character of schizoid detachment and withdrawal from real personal relationships. At that time I regarded the phantasies as all of a piece with the interest in breasts, and as a further extension of regression into the depths of infantile experience, beyond the breast into the womb where he would be 'safe inside'. I have now come to regard that as an incomplete interpretation.

I am inclined to think that interpreting his preoccupation with breasts simply as regression broke down what was in fact a defence against the final regression, and led him back into the ultimate regressive impulse to return to the safety of the womb. Breasts are the concern of the baby who has been born and is

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likelihood of the emergence of a schizophrenic offspring in certain families. If, in fact, the findings of this and other similar studies of the adult schizophrenic are to be of any real practical value, it is to Child Psychiatry that we must hopefully look for the conclusive establishment of our concepts and the possibility of using the knowledge gained to limit or prevent the onset of schizophrenia.

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staying in and reacting to the world outside the womb. His compulsion to cling desperately to breasts and not give them up, was a constructive and forward-looking struggle to defeat his powerful longing to take flight from the post-natal world, return to the womb and be safe inside. Perhaps if, at that time, I had credited his presenting symptom with this constructive motivation, we might both have uncovered his deep regressive drive back to a protected passive state, and also supported in the analysis his struggle to preserve an active, even if on that deep level, as yet only an infantile, breast-seeking ego. Perhaps he withdrew from analysis through fear that it was betraying him into the power of his regressive flight from active living.

I did not at that time recognize the element of determined defence against schizoid withdrawal and regression which I now feel to be the essential purpose of a good many reactions which, considered from the adult point of view only, present the appearance of merely infantile phenomena. All post-natal phenomena, however infantile in themselves, as oral, anal and some genital phenomena are, belong to the sphere of active 'object-relations' of a differentiated kind, and so can serve as a defence against the impulse to withdraw into passive ante-natal security. This is a clue of far-reaching importance for the understanding of the whole range of psychopathological experiences. The facts about regression and phantasies of a return to the womb have long been familiar to analysts. Nevertheless, they have never been securely placed in the theoretical structure of psycho-analysis. Schizophrenic and depressive states were linked by Abraham to the oral-sucking and oral-biting phases of infancy, but phantasies of a return to the womb have simply been taken as part of the phantasy material of regression in general. *The withdrawn schizoid states* have been loosely linked with schizophrenia in much the same way as the 'depressive character' is related to 'depressive psychosis'. Much clinical material makes me feel that they have a more definite significance.

EXISTING THEORETICAL CONCEPTS

The history of psychoanalysis records one major attempt to take account of ante-natal life in a psychologically meaningful way, namely Otto Rank's 'Birth Trauma' theory of neurosis. This misfired because he founded it on the assumption that a physical trauma at birth was the origin of all anxiety. He sought a psychoanalytic means of securing a quick unmasking and reliving of this birth-trauma in the fond hope that neurosis would then prove amenable to rapid cure. Treatment and cure appeared as a process of 'rebirth', implying that in some sense the neurotic personality was still 'in the womb'. Freud exposed the fallacy of this theory as a whole. In a letter to Abraham in February 1924, he wrote:

I do not hesitate to say that I regard this work (of Rank) as highly significant, that it has given me much to think about, and that I have not yet come to a definite judgement about it. . . . We have long been familiar with womb phantasies and recognized their importance, but in the prominence which Rank has given them they achieve a far higher significance and reveal in a flash the biological background of the Oedipus complex. To repeat it in my own language: some instinct must be associated with the birth trauma which aims at restoring the previous existence, one might call it the urge for happiness, understanding there that the concept 'happiness' is mostly used in an erotic meaning. Rank now goes further than psychopathology, and shows how men alter the outer world in the service of this instinct, whereas neurotics save themselves this trouble by taking the short cut of phantasing a return to the womb (Jones, *Freud*, 1957).

Freud regarded this phantasy of a return to the womb as an erotic wish all of a piece with the Oedipal incestuous desire for the mother, and as opposed by the father's prohibition arousing guilt. In March 1924 he wrote again to Abraham:

Let us take the most extreme case, that Ferenczi and Rank make a direct assertion that we have been wrong in pausing at the Oedipus complex. The real decision is to be found in the birth trauma, and whoever had not overcome that would come to shipwreck in the Oedipus situation. Then, instead of our actual aetiology of the neuroses, we

should have one conditioned by physiological accidents, since those who became neurotic would be either the children who had suffered a specially severe birth trauma or had brought to the world an organization specially sensitive to trauma (Jones, 1957).

Freud rejected Rank's views on two grounds principally, that he found the cause of neurosis in a physical accident (thus failing to give a true psychodynamic aetiology) and even then there was no evidence that a quick unmasking of a birth trauma could produce a rapid cure. Freud's criticism was decisive and yet we are no nearer to seeing the true significance of these womb phantasies and of regressive phenomena in general. After the publication in 1926 of Freud's *Inhibitions, Symptoms and Anxiety*, Jones wrote to him: 'You were wise enough to do what none of us others could do: namely to learn something from it all by allowing Rank's views to work on you in a stimulating and fruitful way' (Jones, 1957). We must continue to do that ourselves for the solution of the problem has not yet been arrived at.

Freud regarded phantasies of a return to the womb as having the same basic significance as the Oedipal desire for the mother. The maternal genital, breast and womb were all to be held as alike objects of the incest wish. Wishes for them, when activated in adult life, constitute a progressive return to ever earlier stages of the positive, active, infantile sexual drive. This, I now feel, overlooks an important fact. Further, Freud regards the 'instinctive drive' active in these regressions to 'restore the previous existence' as 'the urge for (erotic) happiness'. This also, I believe, misses the real point, and in such a way as to hide the motivational difference between phantasies of a return to the womb, and breast and incest phantasies. Womb phantasies cancel post-natal object-relations, breast and incest phantasies do not. This fact makes an enormous difference to the ego, which is quite peculiarly dependent on object-relationships for its strength and its sense of its own reality.

The situation revealed by the case material with which I began shows that the patient felt quite simply that the entire external world into

which he had emerged at birth was hostile and dangerous and he was afraid of it. If we are to use 'instinct' terminology, then his regressive longing to get back inside the safe place was caused, not by incestuous longing for erotic happiness with the mother, but by *fear*. It is true fear dictates a return to the mother, but for safety rather than for pleasure. He felt he had been born into a menacing outer world and fear stimulated the instinctive reaction of *flight*, escape, withdrawal back into the secure fortress from which he had emerged. From this point of view it would appear that phantasies of the breast, and of anal and incestuous genital relations with the mother of post-natal existence, are expressions of a struggle by a different part of the personality to 'stay born' and function in the world of differentiated object-relations as a separate ego. They are a defence against the danger of being drawn down into another part of the personality which has 'gone back inside' to save itself from being overwhelmed; for this 'going back inside' does very peculiar and frightening things to the ego. What seems to promise security in one sense is feared as annihilating in another. That was why my patient provided for his emergence in disguise, at least to inspect, to keep up some contact with, the outer world. Rank was close to the ultimate problem in psychodynamics but hit on the wrong solution, in repudiating which Freud, in turn, failed to hit on the right one. The point of view from which the problem could be solved, a point of view arising out of the study of schizoid phenomena, had not then emerged.

Since 1924 much work has been done on the early years of infancy. Melanie Klein has carried intensive analytical investigations back into Freud's pre-Oedipal period. She showed that 'persecutory anxiety' antedates 'depressive anxiety', and that the infant of the first few months is capable of *fear* so intense that it can amount to fear of death in the absolute sense of annihilation. It is true that Mrs Klein regarded this fear of destruction as due ultimately to fear of the internal working of the hypothetical death instinct and therefore as

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an almost wholly endopsychic phenomenon. However, Freud's speculative theory of a death instinct met with little acceptance among analysts, and was rendered unnecessary by the genuinely new development of Mrs Klein's '*internal objects theory*'. This, and her view of the intense fear that can dominate the infant in the earliest period are indispensable for solving the problem of the profoundest regression underlying schizoid states.

Three other contributions bear vitally on our problem, those of Winnicott and Balint from the clinical, and Fairbairn from the theoretical point of view. In this section we are concerned with theory and Fairbairn's revision of psycho-analytical theory appears to me to be the necessary framework within which this problem can be understood. He transferred emphasis from instincts to the self or ego which owns them, and from impulses to the object-relationships within which they become active. He did this under pressure from his clinical work with schizoid patients, and was led beyond Depression to the Schizoid state as the basis of all psychopathological developments. A 'personal' rather than a 'psychobiological' theory eventuated. Freud's analysis of the ego is a conceptualization of depression—a theory of endopsychic structure as essentially a matter of ego and super-ego control and/or repression of raw id-impulses of an anti-social order. Guilt, ultimately in an unconscious form, is the dynamic of the process and the real source of resistance to psychotherapy (Freud, 1923). By contrast, Fairbairn's analysis of the ego is a conceptualization of the schizoid process, and meets the demand that process makes for a theory of endopsychic structure which makes intelligible the 'ego-splitting' that schizoid withdrawal involves. Here the dynamic is not guilt but simple fear. Since schizoid withdrawal is, in the first place, from a bad frightening outer world, Fairbairn does not regard the infant's psychic life as almost wholly endopsychically determined in the way Mrs Klein did.

He regards the infant as from the start a whole, unitary, dynamic ego, however primi-

tive, reacting to his object-world, development being determined by the kind of reception he meets. External object-relations determine the start and future course of endopsychic development in the structural sense. The pristine psyche of the infant is not an unintegrated collection of ego-nuclei, nor is it objectless and purely autoerotic. The work of Mrs Klein in fact outmoded both those elements of the original psychoanalytic theory, though she wavered on the first point. Fairbairn is explicit that the infant from the start is a whole, if primitive, dynamic ego with a unitary striving, at first dim and blind, towards the object-relationships he needs for further ego-development. It is an infantile ego of this kind, already a 'person' in essence in however elementary a way, that we must conceive of as capable of experiencing the intense 'persecutory anxiety', the sheer fear, that Mrs Klein found could characterize the very first few months of life. E. Jones wrote: 'Dr Fairbairn starts at the centre of the personality, the ego, and depicts its strivings and difficulties in its endeavour to reach an object where it may find support... a fresh approach in psycho-analysis' (Fairbairn, 1952).

Fairbairn's theory of endopsychic structure enables us to conceptualize regression as withdrawal from a bad external world, in search of security in an inner world. His conviction that the schizoid problem is the ultimate basis of all psychopathological developments is of major importance. He points out that the problem of the schizoid individual is that his withdrawal in fear results in an inability to effect genuine relationships with personal objects; a fear which is so great, and which leads to a consequent isolation which tends to become so absolute, that in the end he risks the total loss of all objects and therewith the loss of his own ego as well. His attempt to save his ego from persecution by a flight inside to safety creates an even more serious danger of losing it in another way. This is the indispensable starting-point for the study of regression. It is illustrated with startling clarity by the dream of a University lecturer of a marked schizoid intellectual

type. He reported 'I dreamed that I took off from the earth in a space ship. Floating about in empty space I at first thought it was marvellous. I thought "There's not a single person here to interfere with me". Then suddenly I panicked at the thought "Suppose I can't get back".'

The schizoid person can withdraw so thoroughly into himself that he fears losing touch altogether with his external object world. A young wife, who had become deeply schizoid in early childhood through sheer maternal neglect, was faced with the coming into the home of a loud voiced and domineering mother-in-law. She said simply: 'She scares me. I feel I am just going miles away. Its frightening. I fear I'll get so far away I can't get back. I fear I'll go insane.' She had to ring me several nights in succession to keep touch and allay fear.

It is at that point that the schizoid person begins to face the danger of the depersonalization of his ego-of-everyday-life, along with the de-realization of his environment, and he faces the appalling risk of the loss of definite selfhood. The patient first cited had good reason to provide for his emergence in disguise to contact reality outside his castle. Yet this was not 'contact' but only 'observing from a detached standpoint'. He had no real relationship because he was afraid to let the outer world get in, to contact him. Regression and schizoid withdrawal are one and the same thing. Mrs Klein was influenced by Fairbairn's work on the schizoid problem and adopted his term 'schizoid' as an addition to her own term 'paranoid' to describe the earliest developmental 'position', antedating the later 'depressive' position. The combined term 'paranoid-schizoid' position is not, however, strictly accurate. Just as the 'depressive position' is guilt-burdened, so the 'paranoid position' is fear-ridden. The 'schizoid position' is still deeper, for an infantile ego has withdrawn to safety inside away from persecution, or is resolutely seeking to do so.

'Paranoid' and 'schizoid' represent 'danger' and 'flight' respectively. Mrs Klein holds that

failure to work through this total situation renders the child unable later to solve the problems of the depressive position, so that he may regress to and reactivate the earlier problems, as a defence against the pain of unresolvable depression. Mrs Klein regarded the 'depressive position' as the central one for development, the stage at which what Winnicott (1955*b*) calls 'ruth' or 'concern' for others arises, and the development of moral feeling in the civilized person. The earlier paranoid and schizoid or persecuted and withdrawn positions are pre-moral and allow of no concern for others. The question of defence, however, can work the other way round. The paranoid individual faces physical persecution (as in terrors of being torn to pieces) and the depressed individual faces moral persecution (as, for example, in feeling surrounded by accusing eyes and pointing fingers), so that Mrs Klein regards both positions as setting up a primary form of anxiety. In fact, most individuals prefer to face either depressive anxiety (guilt) or persecutory anxiety, or an oscillation between them, rather than face the extreme schizoid loss of everything, both objects and ego. Both persecutory anxiety and depressive anxiety are object-relations experiences, while the schizoid position cancels object-relations in the attempt to escape from anxiety of all kinds.

Though schizoid withdrawal and regression are fundamentally the same phenomenon, they have different meanings for different parts of the total self. From the point of view of the Central Ego, i.e. the conscious self of everyday living, withdrawal means total loss. From the point of view of the part of the self that has withdrawn, it is not 'loss' but 'regression' or retreat backwards inside the small safe place, as represented in the extreme by the phantasy of a return to the womb. We must therefore allow for three basic developmental positions, schizoid (or regressed), paranoid (or persecuted) and depressed (or guilt-burdened); and the paranoid and depressed positions can both be used as a defence against the schizoid position. When an individual is inwardly menaced by an involuntary schizoid flight from reality

and depersonalization (as when too deep fear is too intensely aroused) he will fight to preserve his ego by taking refuge in internal bad-object phantasies of a persecutory or accusatory kind. Then, unwittingly projecting these on to outer reality he maintains touch with the world by feeling that people are either plotting his ruin or criticizing and blaming him for everything he does. Fairbairn classes the paranoid reaction with the psychoneurotic reactions as techniques for the manipulation of internal objects as a defence against the primary dangers of schizoid apathy and depressions, and places the main emphasis on the underlying 'schizoid position' as determinative of all subsequent development. We may agree that the 'depressive position' is decisive for the moral, social and civilized development of the infant, but the clinical material I present appears to me to confirm Fairbairn's view that schizoid phenomena, and the flight from object-relations, are more widespread than depression, are more frequently presented clinically, and that the schizoid position is the vital one for development and for psychopathology.

CLINICAL DESCRIPTION OF THE SCHIZOID PERSONALITY

Womb phantasies represent the extreme schizoid reaction, the ultimate regression, and we shall begin with the more common, mild characteristics which show the extraordinary prevalence of schizoid, i.e. detached or withdrawn, states of mind. In an earlier study of schizoid states (1952) I used the term 'the In and Out Programme' to describe the dilemma in which schizoid people find themselves with respect to object-relationships. They are caught in a conflict between equally strong needs for and fears of close good personal contacts, and in practice often find themselves alternatively driven *into* a relationship by their needs and then driven *out* again by their fears. The schizoid person, because of his fears, cannot *give himself* fully or permanently to anyone or anything with feeling. His most persisting object-relationships are emotionally neutral,

often simply intellectual. This plays havoc with consistency in living. He tends to be unreliable and changeable. He wants what he hasn't got, and begins to lose interest and want to get away from it when he has it. This particularly undermines friendships and love relationships but can become a general discontent with most things. 'Absence makes the heart grow fonder' is true of schizoid people unless too much fear is roused, and then it turns love to hate. The schizoid individual can often feel strong longings for another person so long as he or she is not there, but the actual presence of the other person causes an emotional withdrawal which may range from coldness, loss of interest and inability to find anything to say, to hostility and revulsion. 'Presence makes the heart grow less fond.' Many a patient complains that he carries on long conversations with the therapist 'in his head' but his mind goes blank when in session. So the schizoid person is liable to be constantly 'in and out' of any and every kind of situation.

He usually has a rich and active phantasy life, but in real life is often tepid and weak in enthusiasm, is apt to suffer from inexplicable losses of interest and feels little zest in living. Yet deep inside he has particularly intense needs. He can live in imagination but not in the world of material reality from which he is primarily withdrawn into himself. He wants to realize his dreams in real life but if he finds a dream coming true externally he seems to be unaccountably unable to accept and enjoy it, especially if it concerns a personal relationship. One spinster patient had longed for years to marry and at the age of forty was able to develop her first serious friendship with a male. He was an excellent man in general but a rather reserved bachelor and not very forthcoming as a lover. As long as she was not sure how much he cared for her, she impatiently and often angrily desired him to be more demonstrative. In fact she did draw him out and then it suddenly dawned on her that he really did want her, and she at once took fright, lost interest, and became critical and off-putting. A crisis developed in her which exploded in one session the moment

she entered the consulting room. She stood in the middle of the floor and said in a tense voice: 'I can't come near you. Don't come near me. I'll have to go away, miles away, and live all alone.' I asked her what she was afraid of and she replied: 'If you get close to people, you get swallowed up, you go inside.'

Here was a striking expression of the claustrophobic reaction to close relations that the schizoid person experiences, and which had kept her lonely all her life. She had earlier speculated as to which of two male acquaintances she would like to marry if she had the chance, and said: 'Whichever one I chose, I would immediately feel it ought to be the other one.' The schizoid person dreads that a close relationship will involve loss of freedom and independence. This predicament leads to many variations of reaction. To be 'in' with one person, it may be necessary to have someone else to keep at a distance. To remain 'in' with the marriage partner, may necessitate being 'out' with the children or parents; or to be 'in' with one child may involve being 'out' with another one. Sometimes it leads to deep-seated fluctuations of moods with the same person, varying from periods of warm emotion to other periods of coldness and distance. No consistent full free warmth of affection can be achieved.

This claustrophobic reaction to any genuine close relationship is seen in the dream of a female patient that her sister was being very loving and affectionate to her and she was enjoying it; then suddenly she felt panicky and thought 'We're getting too close, it's dangerous, something dreadful will happen', and she broke away. This 'in and out' policy, alternately dictated by needs and fears, has serious effects on sexual relationships in marriage so that a man may only be able to risk sexual relationships with a woman he is not 'tied' to and does not really love, while he is unconsciously inhibited by deep fears of too close a bodily relationship to the woman he does love. He splits himself into a mental self and a bodily self, and if he is 'in' with the mind he must be 'out' with the body and vice versa. He cannot commit the whole of himself to one person.

Schizoid persons are extremely liable to fear good and loving relationships more than bad and hostile ones, the reason why they face such exceptional difficulties in personal relationships. As soon as they feel they are getting close to someone they experience an automatic and sometimes catastrophically uncontrollable withdrawal of all positive feeling accompanied by great fear. This more commonly appears in the milder form of unaccountable loss of interest. Thus two male patients revealed a history of broken engagements. The engagements were made on the crest of a wave of strong emotion and almost immediately a state of panic and alarm supervened to make them rush to break it off. Their reaction was: 'I feel trapped, doomed.'

This fundamental schizoid fear, which is expressed by patients with monotonous regularity by the use of the words: dread of being smothered, stifled, suffocated, possessed, tied, imprisoned, swallowed up, dominated, absorbed, if a close relationship is risked, is often experienced in vaguer general forms. Thus the safeguarding of independence, even to being unable to accept any suggestion or tolerate any advice, becomes quite an obsession. It begets a fear of committing oneself to anyone or anything in any way. People will change clothes, houses, jobs, interests, as well as chopping and changing in friendships and marriage. *Indecision* is a typical result. Sudden enthusiasms are followed by loss of interest. One patient reported what is in fact quite a common symptom. He said 'I can't really settle myself to read a book. I think "I'd like to read that" and I start it and just when I begin to enjoy it I lose interest and think "Oh! I don't want to go on with this. I'd rather read that other book."' I've got six books all on the go together just now, and can't give myself properly to any one of them to finish it.' The bibliophilic Don Juan is likely to collect and possess books without reading them. This schizoid fear of full self-committal accounts for much inability to concentrate attention in study.

This 'in and out' policy makes life extremely difficult, so we find that a marked schizoid

tendency is to effect a compromise in a half-way house position, neither in nor out. The famous Schopenhauer parable, adopted by Freud, of the porcupines, illustrates the position accurately even if its account of the motivation is too limited. A number of porcupines huddled together because they were cold, but found that they pricked each other with their quills and so drew apart again. They went on in this 'in and out' fashion till ultimately they established a mean distance where they were not quite so cold but also did not prick each other. One patient says: 'I live on the edge of life all the time, in a state of muted feelings, neither very miserable nor really happy. I don't enter into anything enough to enjoy it.' Another patient says: 'I'm a chronic non-joiner. I go to the meetings or lectures of some society and quite like them up to a point, but as soon as someone asks me to join I never go again.' A third patient, of extensive philosophical interests, says: 'I'm an adept at the art of brinkmanship. In group discussion I don't put forward a view of my own. I wait to hear what someone else will say and then I remark "Yes, I rather think something like that" but I'm thinking "I don't really agree with him"'. I won't belong to a recognized school of thought yet I have a dread of going out into the wilderness and standing alone on some definite views of my own. I hover half way. It has stopped me doing any creative work.'

Thus, the schizoid person's needs plus fears of good relationships drive him to ring the changes on being in and out with the same person or thing, being in with one and out with another, or compromising in a half-way position, neither in nor out. Unless skilled help is available to enable the person to grow out of his fears of good relationships, the compromise position is often the best remedy for it is more practically workable than disruptive oscillations. During the course of treatment the patient may have to fall back on this compromise, as it were for a breathing space, from time to time while the anxieties of close relationships are being faced. Yet in this com-

promise position people live far below their real potentialities and life seems dull and unsatisfying. If we could pursue this problem into a mass study of human beings in their everyday existence, we would probably be shocked at the enormous number of people who cannot live life to the full, and not through any lack of means or opportunity, but through lack of emotional capacity to give themselves to anything fully. Here is a cause of boredom, discontents, dissatisfactions, which are often disguised as economic and social but which no economic or political means can cure. The person with schizoid tendencies so usually feels that he is 'missing the bus' and life is passing him by, and it eases his mind superficially if he can find a scapegoat. One patient who lived an unnecessarily restricted life, partly because his withdrawnness involved him in travel phobias, phantasied that he was living at a small wayside country station on the moors, on the side of a main railway line, and all the mainline traffic rushed through and past but never stopped there.

It is far more common to find people exhibiting mild traits of introversion, and poor affective contact with their outer world, than exhibiting signs of true depression, and as Fairbairn has pointed out (1952) most people, when they say they are depressed, really mean that they are apathetic and feel life to be futile, the schizoid state. The poor mixer, the poor conversationalist, the strong silent man, people who live in a narrow world of their own and fear all new ideas and ways, the diffident and shrinking and shy folk, the mildly apathetic who are not particularly interested in anything, the person of dull mechanical routine and robot-like activity into which little feeling enters, who never ventures on anything unfamiliar, are all in various degrees withdrawn and out of the full main stream of living. One patient dreamed that he was in a small boat in a backwater off a main rushing river. It was choked with weeds and he was struggling to get his boat out into the current and could not. Such people have but little effective emotional rapport with their world. They are in the grip

of fear deep down and remain drawn back out of reach of being hurt.

On the other hand, this fundamental detachment is often masked and hidden under a façade of compulsive sociability, incessant talking, and hectic activity. One gets the feeling that such people are acting a somewhat exhausting part. Patients will say 'I feel vaguely that I'm play-acting and that my life isn't real'. The jester or comedian or the person who is 'the life and soul of the party' in public is often 'depressed' in private. Schizoid shallowness of feeling in the part of the personality that deals with the outer world in everyday life is the cause of inability to find much real satisfaction in living. The emotional core of the personality is withdrawn from the self that lives in the external world. The outer self, like a skilled actor, can act even an emotional part mechanically while thinking of other things. A middle-aged woman patient discovered in the course of analysis that she did not need the spectacles she was wearing and discarded them. She said: 'I realize I've only worn them because I felt safer behind that screen. I could look through it at the world.' A somewhat common schizoid symptom is the feeling of a plateglass wall between the patient and the world. Another patient says: 'I feel I'm safe inside my body looking out at the world through my eyes.' One is reminded of the Greek idea of the body as the prisonhouse of the soul, one of many marks of a schizoid mentality in the Greek intellectualist view of life. Winnicott's account of the split between the psyche and the soma throws much light on this. The healthy personality does not feel to be in two parts, one hiding from the world within the other, but whole and all of a piece and active as a unity.

Both the part of the personality which is deeply withdrawn and out of touch, and the part of the personality left to maintain some shallow and precarious contact with the outer world, depleted of emotional vitality, are withdrawn, but the former more profoundly so. The deeply withdrawn part of the whole self is profoundly 'schizoid', extensively 'cut

off'. The ego of everyday life is not so fully cut off. It maintains a mechanical rather than an emotional contact, and tends to feel affectively devitalized, emptied even to the risk of depersonalization. Dreams in which the patient is only an observer of the activities of others are fairly common. An unmarried woman in the thirties dreamed that she stood at a little distance and watched a man and woman kiss, became terrified, and ran away and hid. In her first position she was considerably withdrawn but not entirely out of touch. In her second position she was completely cut off. In fact, patients maintain both positions at the same time in different parts of their total self, and the process of withdrawal in successive stages through fear emerges as a major cause of what we have come to call 'ego-splitting', the loss of unity of the self.

This state of affairs creates two problems. The part of the self that struggles to keep touch with life feels intense fear of the deeper and more secret, withdrawn self, which appears to be endowed with a great capacity to attract and draw down more and more of the rest of the personality into itself. Hence extensive defences are operated against it. If those defences fail, the ego of everyday consciousness experiences a progressively terrifying loss of interest, energy, zest, verging towards exhaustion, apathy, derealization of the environment and depersonalization of the conscious ego. It becomes like an empty shell out of which the living individual has departed to some safer retreat. If that goes too far, the Central Ego, the ordinary outer world self, becomes incapable of carrying on its normal life, and the whole personality succumbs to a full scale 'regressive breakdown'.

Fortunately, there are several ways in which life in the outer world can be kept going in spite of a considerable measure of withdrawal of the vital feeling-self. Ways of living can be devised which do not depend on immediate vitality of 'feeling for' the object-world. Three such ways are common. The schizoid intellectual lives on the basis of 'thinking', the obsessional moralist on the basis of 'duty' and the

'organization-man' on the basis of carrying on automatically in a fixed routine. If the emotionally withdrawn person can by such means ward off a great deal of the impact of real life, and prevent its pressures from playing on the secret inner fear-ridden feeling-life, then a relatively stabilized schizoid character may result; a human being who functions as an efficient robot within a restricted and safe conception of how life is to be lived. Life is the pursuit of truth, not love; the thinking out of an ideology, and ideas become more important than people. It tends to the Greek rather than the Christian view of life, and the scientific rather than the religious view. In religion it exalts theology above love of one's neighbour. In politics, it exalts a party creed above humane feeling, so that people have to be 'done good to' and forced to accept the right kind of social order for their own interest even if you have to kill many of them in cold blood to make the rest accept this nostrum.

This outlook can easily slip over into the unswerving performance of 'duty' in a rigidly conceived way, doing the 'right thing' according to one's own fixed conception without regard to human realities, or concern for the feelings of others; much as Graham Greene's 'Quiet American' created havoc everywhere by the way he 'acted on principle'. Or again life may be reduced to simply carrying on the usual routine, doing the obvious thing, in a mechanical manner, seeking not even to think, in a cold neutral state of mind that freezes everyone around but is safe for the person concerned. All degrees of this kind of stabilization of the schizoid personality occur, from mild tendency to fixed type.

The schizoid intellectual is a particularly important type, for he can become a serious social menace especially if he comes to political power. Highly abstract philosophy seems unwittingly designed to prove Descartes's dictum, 'Cogito, ergo sum', 'I think, therefore I am', the perfect formula for the schizoid intellectual's struggle to possess an ego. A natural human being would be more likely to start

from 'I feel, therefore I am'. Even the schizoid person can become rapidly convinced of his own reality for the time being by feeling angry, whereas his thinking is usually a not very convincing struggle to hold on to a somewhat desiccated personal reality. This happens when a person cannot go to sleep but lies awake 'thinking'. Thus a patient suffering from a very traumatic bereavement felt 'emptied' and would ward off attacks of depersonalization in the night by lying awake for hours just thinking. She said it did not seem to matter what she thought about so long as she continued to think. When an elaborate ideology is fanatically defended it is usually a substitute for a true self.

Behind all these methods by which the schizoid person struggles to save himself from too far-reaching a withdrawal from outer reality with its consequences of loss of the ego, lies the hidden danger of a secret part of the personality which is devoted to a fixed attitude of retreat from life in the outer world. It is the part of the total self that most needs help and healing. Its two most extreme expressions are regressive breakdown and phantasies of a return to the womb. In face of this internal threat, the business of maintaining an ego is fraught with unceasing anxiety. The schizoid problem is an 'Ego' problem. Like the British Army at Dunkirk, the too hard-pressed child retreats to save himself from annihilating defeat, so that back in a protected security he may recover strength; an analogy which suggests that the schizoid withdrawal, if we understand it aright, is a healthy phenomenon in the circumstances which initiate it. By retreating back 'inside the safe place', the British Army gained the chance to recover and lived to fight another day. Winnicott holds that under stress the infant withdraws his real self from the fray to await a better chance of rebirth later on (1955*a*). Yet this retreat to save a 'hidden ego' also goes a long way to undermine the 'manifest ego'. This is the problem presented for solution by schizoid data.

CAUSES AND STAGES OF SCHIZOID WITHDRAWAL

1. *Fear and flight from external reality.* The most pathological schizoid withdrawal takes place astonishingly early, in the first year of life. It can, of course, occur at any time of life as a generalized reaction, but the more it is found to be structurally embedded in the personality the earlier it originally occurred. It can then, certainly, be intensified and consolidated all through later childhood and evoked by pressures in real life at any time, but there is little doubt that in the beginning it is associated with what Melanie Klein called 'persecutory anxiety' and 'the infantile anxiety situations'. It is a 'fear and flight' reaction in the face of danger. The view of the later Freud and of Mrs Klein that the *ultimate* source of the danger is wholly internal, a 'Death Instinct', innate active aggression working inwardly, threatening destruction against the primary psyche, has found no general acceptance. It would be unscientific to fall back on such a speculative idea when satisfactory clinical analysis is available. The view of the earlier Freud that psychopathological development began, not with innate aggression but with the libidinal drives of the sexual instinct aiming at erotic pleasure and proving to be incompatible with social reality, at least implied that the source of the trouble was more in the environment than in the infant. The world into which the infant was born could not tolerate his nature and his needs and he came up against painful frustrations. However, this view does not cover all the facts.

Fairbairn takes a wider view of libidinal need as not limited to the sexual but embracing all that is involved in the need for personal relationships, on however simple and primitive a level at the beginning: the goal of libidinal need is not pleasure but the object (at first the breast and the mother). The frustration of libidinal need for good object-relations both arouses aggression and intensifies libidinal needs till the infant fears his love-needs as destructive towards his objects. In the later 'depressive

position' which Winnicott calls the stage of 'ruth' or 'concern for the object' this would lead to guilt. But at this earliest stage it leads to the schizoid withdrawal, a simple fear reaction, away from the danger of devouring and therefore losing the love-object. Schizoid persons have given up the outward expression of needs, while also being haunted by the fear of losing love-objects. One patient says: 'I can't make moderate demands so I don't make any at all', and another insists 'I lose everyone I love'. Yet the schizoid fear is not so much on behalf of the object as on behalf of the ego and the consequences to it of losing the object. Here lies the difference between the moral and the pre-moral level of development. The schizoid personality is basically on a pre-moral level; hence the horrifying callousness schizoid people can manifest. It is not in accordance with Fairbairn's psychodynamic outlook to treat these libidinal needs as discrete entities demanding satisfaction in and for themselves. They are the needs of an ego. Since the need for an object arises from the fact that without object-relations no strong ego-development is possible, we must conclude that the satisfaction of libidinal needs is not an end in itself but is an experience of good-object relationships in which the infant discovers himself as a person, and his ego-development proceeds firmly and self-confidently. Fairbairn's view brings out the question of ego-growth in weakness or in strength as the background of all problems arising out of fears, conflicts and withdrawals over frustrated needs.

Deprivation of needs is, however, not the only cause of schizoid withdrawal, and Winnicott emphasizes what seems to be an even more primitive situation. Not only must the mother meet the infant's needs when he feels them, but she must not force herself on him in ways and at times that he does not want. That constitutes 'impingement' on the as yet weak, immature and sensitive ego of the infant. He cannot stand this and shrinks away into himself. There are many other sources of 'impingement' in loveless, authoritarian and quarrelsome families and often sheer fear is aroused in the tiny

child. Fairbairn has also recently stressed in private conversation that trouble arises not only over the child's needs for the parents, but also over the parents' pressures on the child who is often exploited in the interests of the parents' needs, not the baby's. The startle-reaction to sudden loud noise is perhaps the simplest case of fear at impingement, and such impingement experiences, particularly at the hands of parents, begin the building up of basic impressions that the whole outer world is not supporting but hostile.

Judging by the reflexion of these early events in the psychopathology of adults, this factor of impingement and pressure of a hostile environment, bearing to an intolerable degree on the tender infant mind, is the true source of 'persecutory anxiety', of fear of annihilation, and of flight back inside, of withdrawal of the emotionally traumatized infant Libidinal Ego into itself out of reach of the dangerous outer world. What an adult may do consciously, as in the case of a wife who felt that her husband was inconsiderate and said 'I built a wall round myself so that I should not be hurt', the infant does instinctively. He takes flight inwards from the outer world. Fear of deprived and therefore dangerous active oral-sadistic libidinal needs belongs to a higher level, that of the struggle to remain in object-relationships. It precipitates withdrawal in two ways, however, through fear of devouring and losing the object, and through fear of retaliation and of being devoured by the object. This latter fear may develop into guilt and the fear of punishment. Withdrawal from direct frightening impingement by the object in the first place is more primitive. Deep fear-enforced withdrawal from object-relations is then to a regressed passive level of a womb-like state inside. Severe schizoid states disclose a total fear of the entire outer world, and deprivation and impingement combine. The world is a frightening emptiness when it does not respond and meet the infant's needs, and a frightening persecutor when it actively and hurtfully impinges. The infant cannot develop a secure and strong ego-sense either in a vacuum or under intoler-

able pressure and he seeks to return to a vaguely remembered earlier safe place, even though in fact he can only withdraw into isolation within himself.

With one patient, a doctor, suffering from apparent 'depression' which was really apathy, indifference, and loss of zest for work, the analytical uncovering of a clear-cut castration fear, led to an outbreak of apathy, loss of interest and energy so serious that for a time he could hardly carry on his daily work. It was a herculean effort to get himself out of bed and one day he was quite unable to get up. He lay in bed all day, curled up and covered over with bed-clothes, refusing food and conversation and requiring only to be left alone in absolute peace. That night he dreamed that he went to a confinement case and found the baby sitting on the edge of the vagina wondering whether to come out or go back in, and could not decide whether to bring it out or put it back. He was experiencing the most deeply regressed part of his personality where he felt and phantasied a return to the womb, an escape from sheer fear of castration, not by father but by mother and aunt. The whole family life had been one of anxiety, a nagging mother, a drinking father, quarrelling parents, pressure on the child to be 'no trouble' from babyhood, and then as he grew older a mother and aunt who made actual and literal castration threats, sometimes as a joke, sometimes semi-seriously. 'If you're not a good boy I'll cut it off', accompanied by half gestures towards the little boy with knife or scissors which terrified him. But that well-founded castration complex, which brought back a wealth of detailed memories, was but the end-product of all the child's memories of a mother whose basic hostility to him he had always sensed. His serious schizoid-regressive illness was the result of a withdrawal into himself which must have taken place first at an extremely early age to escape intolerable impingement by his family life.

Deprivation of libidinal needs and separation anxiety play their part along with impingement in provoking withdrawal, not only by intensifying needs till they seem too dangerous

to express, but also by the threat of emptying the ego. One very schizoid agoraphobic patient reacted primarily to gross neglect and rejection by her mother in the first year. Outwardly the position improved at about 1 year when a neighbour said 'Excuse me Mrs X but you only take notice of your older child, you never take any notice of the baby'. The mother's guilt then made her subject the baby to oppressive attention but the damage was done. Before the vacuum changed into a smothering environment the mother's emotional withdrawal from the child had been met by the child's emotional withdrawal from the mother. She developed so-called epileptic fits in the first year, which faded out into 'dizzy turns'. They must have represented the collapse of her conscious ego as what Winnicott would call her 'real self' took flight from a world in which she could find nothing by which she could live. In after years, when the patient's husband was called up for military service, this represented at bottom her mother's desertion of her and she broke down in acute anxiety, could not be left alone, and remained house-bound, withdrawn from life and 'safe inside'. Late in analysis, when she felt she had got back to the very beginning, she reported a dream. 'I was small and I pointed a brush at mother like a magnet to draw her to me. She came but said "I can't be bothered with you, I'm going to help Mrs So-and-So". I felt a terrible shock, like an electric shock, inside—"So you didn't want me"—as if the bottom dropped out of me, life seeped away and I felt emptied.' Did that 'shock' represent her original 'epileptic fits'? During that same night she dreamed that she 'just fell, collapsed', and in fact she did do that next day. The importance of an object-relationship for the maintenance of the ego, both in real life and in psychotherapy, is clear from the dream in which this patient fell. She dreamed that she met a woman and asked her the way; when the woman did not answer she 'just fell'. Then she was with me and I took her hand 'to warm her up', i.e. bring her back to life. One seriously schizoid male patient who had to sit during sessions so that he could see me, at times would

begin to fade away into unconsciousness, a process which was only arrested if I held his hand till he felt securely in touch again.

Impingement and rejection or deprivation of needs for object-relationships must be bracketed together as defining the traumatic situation which drives the infant into a retreat within himself in search of a return to the womb. Probably deprivation in the sense of 'tantalizing refusal' leads to *active* oral phenomena while impingement and deprivation as 'desertion' lead to shrinking away inside into a passive state.

2. *A two-stage withdrawal, from external and internal bad objects.* The previous section describes the origins of the first stage of what appears to be a two-stage retreat from bad-object relationships. This initial escape is from the outer material world into an inner mental one. But contact with the object-world cannot be given up, especially at this early age, without threatening to lead to loss or emptying of the ego. Thus part of the total self must be left to function on the conscious level and keep touch with the world of real external objects. If that were not done, and relationship with outer reality were wholly given up, the infant would presumably die. Thus a 'splitting' of the hitherto unitary, pristine ego occurs, into a part dealing with the outer world (Freud's 'reality-ego' and Fairbairn's 'Central Ego') and a part that has withdrawn into the inner mental world.

The withdrawn part of the total self must also, however, keep in object-relationships if it is to maintain its experience of itself as a definite ego. The 'mind', instead of being simply an active function dealing with the outer world, becomes a place to live in. As Melanie Klein has shown, the infant internalizes his objects and builds up an inner world of object-relations. Fairbairn regards the infant as internalizing his unsatisfying objects in an effort to master them in inner reality because he cannot master them in the outer world. In the result, however, they are felt to be as powerful and terrifying in inner reality as in outer, a 'fifth column' of internal persecutors

shows how little his academic life had touched his deeper mentality, illustrates this two-stage retreat: 'I was on a tropical South Seas island and thought I was all alone. Then I found it was full of white people who were very hostile to me and surged at me. I found a little hut on the shore and rushed into it and barred the door and windows and got into bed.' He has retreated from civilization to his lonely island (his internal world) only to find that his bad objects, white people, are still with him. So he makes a second retreat which is a complete regression. In defence against this he had twice succumbed to a manic psychosis followed by a depressed, apathetic state. The fact that this manoeuvre involves a splitting of the withdrawn Libidinal Ego into two is seen in another dream in which the patient was in the consulting room of the analyst. There were two little boys in the room whom he wanted to send out, but the analyst was looking after them and wished them to remain. They sat together on chairs; one was unnaturally alert and watchful, keeping in touch with everything that went on, while the other had a dull expressionless face and took no notice of anything at all, but was completely withdrawn. Here are the active Oral Ego and the passive Regressed Ego, along with the Central Ego, i.e. the patient in his familiar everyday self, sitting apart in an armchair. But his Antilibidinal Ego was in concealed partnership with the Central Ego and hostile to the children.

3. *Regression to a Symbolic Womb.* Since this Regressed Ego is the basis of the most dangerous and undermining psychopathological developments, it is as well to reflect on the fact that it is in itself a necessary, reasonable and healthy reaction to danger. Something is wrong primarily not with the infant but with the environment. The problems arise from the fact, not that what the frightened and regressed infant seeks is psychopathological in itself, but that it is something that, however realistically needed, it ought not to be driven to want, and in any case is exceedingly difficult to obtain in any substitute form once the actual womb has been left. The primitive wholeness of the ego is

now lost in a fourfold split, a depleted Central Ego coping with the outer world; a demanding Libidinal Ego inside persecuted by an angry Antilibidinal Ego (the Kleinian internal world); and finally a Regressed Ego which knows and accepts the fact that it is overwhelmed by fear and in a state of exhaustion, and that it will never be in any fit state to live unless it can, so to speak, escape into a mental convalescence where it can lie quiet, protected, and be given a chance to recuperate.

I have heard Fairbairn's scheme of endopsychic structure criticized as too complicated (though we do not criticize physics on such grounds). The criticism is not valid. Of Freud's scheme Colby writes: 'There are . . . theoretical disadvantages to the id-ego-superego model. Today its simplicity makes it insufficient to conceptualize specifically enough the manifold functions of psychic activity. . . . In psychoanalysis our knowledge has increased in such a way that to subsume the complexities of psychic activity under three undivided categories is to stretch generalizations perhaps too far (1955).' The complexity describes the terrible disintegration that can be forced on the tender and weak infantile ego if it is subjected to pressures it is too immature to bear. Freud wrote in his last book: 'The weak and immature ego of the first phase of childhood is permanently damaged by the strain put upon it in the effort to ward off the dangers that are peculiar to that period of life (1938).' He further states: 'The view which postulates that in all psychoses there is a *split in the ego* could not demand so much notice, if it were not for the fact that it turns out to apply also to other conditions more like the neuroses and, finally, to the neuroses themselves (1938).' Fairbairn's scheme reduces to order the tangled mass of self-contradictory reactions presented to us as clinical material, and reveals this permanent damage to the immature ego in the form of the 'ego-splitting' of which Freud speaks. The additional structural complexity that I have added is called for by clinical data that we have long failed to include properly in any structural scheme. It conceptualizes the ultimate desper-

ate bid made by the overtaxed infant to save himself, a move which perpetuates thereafter what we may call a 'structural headquarters of fear' in the personality as a basis for the danger of regressive breakdown in later life.

The *Regressed Ego* denotes, not a freely available generalized 'fear and flight' reaction but the deepest structurally specific part of the complex personality, existing in a settled attitude of fear, weakness, withdrawal and absolute dependence not in the active post-natal infantile sense but in a passive ante-natal sense. It represents the most profoundly traumatized part of the personality and is the hidden cause of all regressive phenomena from conscious escapist phantasies to complete schizoid apathy, unless its need is understood and met; but there lies the greatest difficulty and challenge to therapy. In a letter to the writer dated 1 January 1960, Fairbairn accepted this extension of his structural theory. He wrote: 'I consider your concept of the splitting of the Libidinal Ego into two parts—an oral needy Libidinal Ego and a Regressed Libidinal Ego—as an original contribution of considerable explanatory value. It solves a problem which I had not hitherto succeeded in solving.' Winnicott wrote on 31 October, 1960: 'Your split in the Libidinal Ego seems to have a lot in common with my "hidden true self" and the "false self built upon a compliance basis" (a defence in illness, and in health simply the polite self that does not wear its heart on its sleeve). I do think that research can usefully be based on these ideas that are in the air and which you are developing in your own way.' It is a pleasure to quote these two writers to whose pioneering work in theory and therapy I owe most for stimulus. I would, however, think that Winnicott's 'false compliant self in health' corresponds to the Central Ego of Fairbairn and his 'False compliant self as a defence in illness' corresponds to Fairbairn's Antilibidinal Ego, especially in its function of hating weakness. This to me especially seems to warrant the term 'false self'.

How can the need of the exhausted Regressed Ego for recuperation in and rebirth from a

reproduction of the womb-state be met at all, and how can it be met without the risk of undermining the Central Ego of everyday living? That seems to be the ultimate problem for psychotherapy. There is evidence that in some cases it can be done, though we have almost everything to learn about this process. At least it is safe to say that it cannot be done without the aid of a psychotherapist, i.e. the setting up of a therapeutic object-relationship. This is the significance of Winnicott's work on 'therapeutic regression'. The unsatisfactory results of psychotherapy hitherto must be the result of this problem not having been recognized earlier. When the individual is left to himself, he can only do what he was driven to do as a child, struggle to repress his regressive trends by developing a hard and hostile attitude to any 'weakness' in himself, i.e. develop an Antilibidinal Ego which is really the child's determined effort to keep himself going by being independent (Guntrip, 1960). If his Regressed Ego becomes irresistible he can only provide for it by a regressive illness. Perhaps, if he did not give in to that in time and compel his environment to take responsibility for him, he would die of psychic self-exhaustion. The psychotherapist must help the patient to find a way of substituting a controlled and constructive regression for an uncontrolled and involuntary one in the form of an illness that might be an irretrievable disaster for the patient's real-life status. But I believe that this also cannot be done, not only without the aid of a psychotherapist, but of a psychoanalytical psychotherapist; for the main obstacle to the patient's accepting a constructive regression in treatment is his own Antilibidinal Ego which needs the closest analytical uncovering. The final aim of this therapy is to convert regression into rebirth and regrowth. This must result from the Regressed Ego finding for the first time an object-relationship of understanding acceptance and safeguarding of its rights, with a therapist who does not seek to force on the patient his pre-conceived views of what must be done; but who realizes that deep down the patient knows his own business best, if we can

or saboteurs who have infiltrated into the inner world where the infant has sought relief inside himself from pressure. A serious predicament has arisen. On the face of it no further retreat seems possible and a series of fresh manoeuvres are made. Fairbairn has described these in terms of 'object-splitting' and 'ego-splitting' processes, which build up the structure of the inner world in terms of endopsychic object-relations. The internal unsatisfying object is split into its three main aspects, libidinally exciting, libidinally rejective, and emotionally neutral or good and undisturbing. The last or Ideal Object is projected back into the real object and what has all the appearance of an external object-relationship is maintained with it by the Central Ego, the ordinary ego of everyday living. Nevertheless, this is not a properly objective relation, for the object is not fully realistically perceived but only experienced in the light of a partial image projected from inner reality. Thus, once some measure of schizoid withdrawal has been set up, such contact with the outer world as is maintained is defective and governed by the projection of partial and oversimplified images of the object: a fact constantly demonstrated by the poor judgement of others, the over- or under-estimation of either good or bad qualities, commonly displayed by people.

Then, while the real object (the actual parent) is unrealistically idealized, his or her exciting and rejective aspects remain as distinguishable and separated phantasied objects of the infant's need for relationships in the inner world. Thus, the unity of that part of the ego which has withdrawn inside away from outer reality becomes split into an ego attached to the Exciting Object and an ego attached to the Rejective Object. Just as the Exciting Object arouses libidinal needs while the Rejective Object denies them, so the attachment to the Exciting Object results in a *Libidinal Ego* characterized by ever-active and unsatisfied desires which come to be felt in angry and sadistic ways; and the attachment to the Rejective Object results in an *Antilibidinal Ego*

based on an identification which reproduces the hostility of the Rejecting Object to libidinal needs. Inevitably the Libidinal Ego is hated and persecuted by the Antilibidinal Ego as well as by the Rejective Object, so that the infant has now become divided against himself. This is easy to recognize in the contempt and scorn shown by many patients of their own needs to depend for help on other people or on the analyst. It is seen also in the fear and hate of weakness that is embedded in our cultural attitudes. The internal persecution of the Libidinal Ego by the Antilibidinal Ego is vividly seen in the dream of a male patient. He was sitting in an armchair in my room wanting to relax, but at the same time he was also standing behind the chair looking down on the 'him' that was sitting in the chair, with an expression of hate and hostility and raising a dagger to kill the needy weak self.

At this stage, the part of the ego which has withdrawn from outer reality has now created for itself a complex inner world of objects both exciting and persecuting. The existence of these internal objects enables the parts of the ego which maintain relations with them to retain ego-sense. It seems evident that the real need which dictates the creation of Melanie Klein's world of internal objects, good and bad, and the processes of ego-splitting described by Fairbairn, is not simply the urge to master the object but the vital need of the psyche to retain an ego-sense. This can only be done by maintaining object-relations at least in the inner mental world, after withdrawing in that part of one's personal life from the outer material one. So long as a continuing phantasy life can be kept going by the Libidinal and Antilibidinal Egos, the ego is kept in being though cut off from outer reality. At one time the Libidinal Ego is sadistically phantasying the incorporation of its Exciting Object in inner reality, at another the Antilibidinal Ego has possessed itself of the sadism and along with the Rejective Object phantasies crushing or slave-driving the masochistically suffering Libidinal Ego. (According to Fairbairn, internal objects are psychic structures just as much

as partial egos are. The total psychic self 'impersonates' objects to itself in the inner world so as to retain ego-sense in phantasied relations.) Though this kind of inner life results in states of acute 'persecutory anxiety', the ego is still in being; it has not succumbed to depersonalization after breaking off emotional rapport with objects in real life. This is indeed the rationale of the creation and maintenance of the Kleinian Internal Objects world: it is a defence against ego-loss, which shows why it is so hard for the patient to give it up.

Yet the position of the withdrawn ego is little bettered, for its enemies have infiltrated into its safe retreat where they are even harder to get away from than before. Freud realized that when, in the early days of psychoanalysis, the sources of internal dangers were thought to be 'instinct-derivatives'. He stressed that the ego cannot escape from what is actually a part of internal reality. This, however, turns out not to be entirely true; or at least it is indubitably true that the ego makes one further attempt to escape from the intolerable internal pressures put upon it by its post-natal world of bad objects. It is the Libidinal Ego which is the part of the originally whole and now split ego in which the persecutory pressure is felt; and clinical facts have suggested to me that it repeats, in face of the *internal* bad-object world, the same manoeuvre that was made by the whole ego when it sought to withdraw from the *external* bad-object world. It leaves parts of itself to carry on such relations as are possible, in sado-masochistic terms, with the Exciting and Rejecting Objects of the internal phantasy world, while the traumatized, sensitive and exhausted heart of it withdraws deeper still. The evidence provided by regressive behaviour, regressive symptoms and regressive dreams and phantasies, shows that this most deeply withdrawn ego feels and phantasies a return to the womb, safe inside the 'fortress' from which it probably still has some dim memory of having emerged. Only thus can the clinical facts be conceptualized, facts of the distinct and separate functioning of an active oral infantile Libidinal Ego tied to a terrifying

world of internal bad-object relations, and of a passive regressed Libidinal Ego concerned only with an imperative need to escape and be 'safe inside' and giving up all definite object-relations in favour of an enclosing protective environment. It is the irresistible pull of this Regressed Ego under certain circumstances that precipitates the schizoid breakdown in the most extreme cases, but its powerful pull manifested in the teeth of stubborn resistance and defence accounts for all the tensions and illnesses that arise out of this desperate struggle to possess and to retain an ego.

I first made this suggestion of a final split in the Libidinal Ego itself, in an article on 'Ego Weakness and the Hard Core of the Problem of Psychotherapy' (1960) and traced out some of its consequences in the closing section of a book 'Personality Structure and Human Interaction' (1961). Here I have sought to give fuller clinical evidence for this view. In addition to the two levels of ego-splitting which Fairbairn describes, namely, first that between the Central Ego in touch with the outer world and a withdrawn ego in the inner world, and second the further splitting of this withdrawn ego into the Libidinal Ego and the Antilibidinal Ego, there is a third and ultimate split in the Libidinal Ego itself. It divides into an active sado-masochistic Oral ego which continues to maintain internal bad-object relations, and a passive Regressed Ego which seeks to return to the antenatal state of absolute passive dependent security; here in quietude, repose and immobility it may find the opportunity to recuperate and grow to a rebirth, as Winnicott holds (1955a.) I suggest that this Regressed Ego is identical with what Winnicott calls the 'true self' put into cold storage to await the chance of rebirth in better conditions. I do not, however, feel sure whether the Regressed Ego feels itself to be 'frozen in cold storage' (frozen in fear probably) or whether it feels hidden in the deepest unconscious in the warmth of an hallucinated intra-uterine condition. Some patients appear to feel one way and others the other.

The dream of a University Lecturer which

shows how little his academic life had touched his deeper mentality, illustrates this two-stage retreat: 'I was on a tropical South Seas island and thought I was all alone. Then I found it was full of white people who were very hostile to me and surged at me. I found a little hut on the shore and rushed into it and barred the door and windows and got into bed.' He has retreated from civilization to his lonely island (his internal world) only to find that his bad objects, white people, are still with him. So he makes a second retreat which is a complete regression. In defence against this he had twice succumbed to a manic psychosis followed by a depressed, apathetic state. The fact that this manoeuvre involves a splitting of the withdrawn Libidinal Ego into two is seen in another dream in which the patient was in the consulting room of the analyst. There were two little boys in the room whom he wanted to send out, but the analyst was looking after them and wished them to remain. They sat together on chairs; one was unnaturally alert and watchful, keeping in touch with everything that went on, while the other had a dull expressionless face and took no notice of anything at all, but was completely withdrawn. Here are the active Oral Ego and the passive Regressed Ego, along with the Central Ego, i.e. the patient in his familiar everyday self, sitting apart in an arm-chair. But his Antilibidinal Ego was in concealed partnership with the Central Ego and hostile to the children.

3. *Regression to a Symbolic Womb*. Since this Regressed Ego is the basis of the most dangerous and undermining psychopathological developments, it is as well to reflect on the fact that it is in itself a necessary, reasonable and healthy reaction to danger. Something is wrong primarily not with the infant but with the environment. The problems arise from the fact, not that what the frightened and regressed infant seeks is psychopathological in itself, but that it is something that, however realistically needed, it ought not to be driven to want, and in any case is exceedingly difficult to obtain in any substitute form once the actual womb has been left. The primitive wholeness of the ego is

now lost in a fourfold split, a depleted Central Ego coping with the outer world; a demanding Libidinal Ego inside persecuted by an angry Antilibidinal Ego (the Kleinian internal world); and finally a Regressed Ego which knows and accepts the fact that it is overwhelmed by fear and in a state of exhaustion, and that it will never be in any fit state to live unless it can, so to speak, escape into a mental convalescence where it can lie quiet, protected, and be given a chance to recuperate.

I have heard Fairbairn's scheme of endopsychic structure criticized as too complicated (though we do not criticize physics on such grounds). The criticism is not valid. Of Freud's scheme Colby writes: 'There are . . . theoretical disadvantages to the id-ego-superego model. Today its simplicity makes it insufficient to conceptualize specifically enough the manifold functions of psychic activity. . . . In psychoanalysis our knowledge has increased in such a way that to subsume the complexities of psychic activity under three undivided categories is to stretch generalizations perhaps too far (1955).' The complexity describes the terrible disintegration that can be forced on the tender and weak infantile ego if it is subjected to pressures it is too immature to bear. Freud wrote in his last book: 'The weak and immature ego of the first phase of childhood is permanently damaged by the strain put upon it in the effort to ward off the dangers that are peculiar to that period of life (1938).' He further states: 'The view which postulates that in all psychoses there is a *split in the ego* could not demand so much notice, if it were not for the fact that it turns out to apply also to other conditions more like the neuroses and, finally, to the neuroses themselves (1938).' Fairbairn's scheme reduces to order the tangled mass of self-contradictory reactions presented to us as clinical material, and reveals this permanent damage to the immature ego in the form of the 'ego-splitting' of which Freud speaks. The additional structural complexity that I have added is called for by clinical data that we have long failed to include properly in any structural scheme. It conceptualizes the ultimate desper-

ate bid made by the overtaxed infant to save himself, a move which perpetuates thereafter what we may call a 'structural headquarters of fear' in the personality as a basis for the danger of regressive breakdown in later life.

The *Regressed Ego* denotes, not a freely available generalized 'fear and flight' reaction but the deepest structurally specific part of the complex personality, existing in a settled attitude of fear, weakness, withdrawal and absolute dependence not in the active post-natal infantile sense but in a passive ante-natal sense. It represents the most profoundly traumatized part of the personality and is the hidden cause of all regressive phenomena from conscious escapist phantasies to complete schizoid apathy, unless its need is understood and met; but there lies the greatest difficulty and challenge to therapy. In a letter to the writer dated 1 January 1960, Fairbairn accepted this extension of his structural theory. He wrote: 'I consider your concept of the splitting of the Libidinal Ego into two parts—an oral needy Libidinal Ego and a Regressed Libidinal Ego—as an original contribution of considerable explanatory value. It solves a problem which I had not hitherto succeeded in solving.' Winnicott wrote on 31 October, 1960: 'Your split in the Libidinal Ego seems to have a lot in common with my "hidden true self" and the "false self built upon a compliance basis" (a defence in illness, and in health simply the polite self that does not wear its heart on its sleeve). I do think that research can usefully be based on these ideas that are in the air and which you are developing in your own way.' It is a pleasure to quote these two writers to whose pioneering work in theory and therapy I owe most for stimulus. I would, however, think that Winnicott's 'false compliant self in health' corresponds to the Central Ego of Fairbairn and his 'False compliant self as a defence in illness' corresponds to Fairbairn's Antilibidinal Ego, especially in its function of hating weakness. This to me especially seems to warrant the term 'false self'.

How can the need of the exhausted Regressed Ego for recuperation in and rebirth from a

reproduction of the womb-state be met at all, and how can it be met without the risk of undermining the Central Ego of everyday living? That seems to be the ultimate problem for psychotherapy. There is evidence that in some cases it can be done, though we have almost everything to learn about this process. At least it is safe to say that it cannot be done without the aid of a psychotherapist, i.e. the setting up of a therapeutic object-relationship. This is the significance of Winnicott's work on 'therapeutic regression'. The unsatisfactory results of psychotherapy hitherto must be the result of this problem not having been recognized earlier. When the individual is left to himself, he can only do what he was driven to do as a child, struggle to repress his regressive trends by developing a hard and hostile attitude to any 'weakness' in himself, i.e. develop an Antilibidinal Ego which is really the child's determined effort to keep himself going by being independent (Guntrip, 1960). If his Regressed Ego becomes irresistible he can only provide for it by a regressive illness. Perhaps, if he did not give in to that in time and compel his environment to take responsibility for him, he would die of psychic self-exhaustion. The psychotherapist must help the patient to find a way of substituting a controlled and constructive regression for an uncontrolled and involuntary one in the form of an illness that might be an irretrievable disaster for the patient's real-life status. But I believe that this also cannot be done, not only without the aid of a psychotherapist, but of a psychoanalytical psychotherapist; for the main obstacle to the patient's accepting a constructive regression in treatment is his own Antilibidinal Ego which needs the closest analytical uncovering. The final aim of this therapy is to convert regression into rebirth and regrowth. This must result from the Regressed Ego finding for the first time an object-relationship of understanding acceptance and safeguarding of its rights, with a therapist who does not seek to force on the patient his pre-conceived views of what must be done; but who realizes that deep down the patient knows his own business best, if we can

understand his language. But before the problem of therapy can be solved we must understand how the patient's struggles to save himself form a resistance to the true therapy.

THE FIGHT AGAINST REGRESSION

1. *The determined drive backwards.* We have stated that, left to himself, the individual can only either provide for his Regressed Ego in the extreme case by illness, owing to the practical difficulties of providing for it in any other way, or else seek to suppress it as an internal danger threatening to undermine his adjustment to real life in the outer world. The vague influence of a regressed part of the total self is easy to recognize in many people as an attitude of getting through life with as little trouble as possible, getting out of things if they can, and having to push themselves to do what they must. Generally a sustained if automatic effort is made over the years to stave off regression in any more definite sense, though many people have a history of periodic breakdowns say every four or five years, with minor signs of nervous strain and tension in between. In many cases, however, very vigorous defences of an antilibidinal nature (antilibidinal towards the self even when apparently libidinal towards others) are built into the personality and direct very energetic if over-tense drives into real life.

The individual from the beginning has had to cope with the problem himself. No one has really known or understood what was going on in the child, and so far as his deeper life was concerned he had to bring himself up and manage himself in secret. Hence the self-centredness and introversion of schizoid persons. Life becomes a long, hidden, tension-filled struggle against regressive trends. Tremendous tension can be masked by a calm exterior, but is often not masked, breaking out physically if not in other ways. Melanie Klein and Fairbairn treat the psychoneurotic states as defences against the psychotic dangers of schizoid apathy and depression. If, however, the deepest danger is regression to passivity, we

must regard all states, psychotic as well as neurotic, in which an 'active' ego struggles and suffers, as defences.

The ultimate characteristic of the Regressed Ego is dependent passivity, the vegetative passivity of the intra-uterine state which fostered original growth and can foster recuperation. Nature heals in a state of rest. That is the goal. Nevertheless, the Regressed Ego shows great energy and activity in pursuit of its goal, an activity in reverse that carries it not into life but out of it. There is a great deal of research to be done on various aspects of regression for, clinically, the picture presented is confusing. One comes across states which suggest that there is a Regressed Ego which feels to be already 'in the womb' and oblivious to all else, or if not in a warm safe hiding place then completely withdrawn, immobilized in fear, and having never emerged since the first drastic schizoid retreat in infancy. Some patients, after long analysis, can find themselves suddenly totally 'cut off' and living in the deepest, most hidden schizoid part of their total self which they have at last contacted and must live in and with till they regain emotional rapport with the outer world at that deep level. Again, a Regressed Ego, which in itself seems quite dissociated, exerts a powerful pull on the rest of the personality, drawing it down while it resists frantically. Yet again, at times the whole self seems to have become a Regressing Ego showing great energy in a drive backwards towards the goal not as yet reached; and sometimes the Regressed Ego is phantasied as in the womb and resisting every effort to force it to a premature rebirth.

Thus a male patient in the thirties dreamed that he was working, doing business correspondence at a table, when he suddenly felt an invisible and irresistible pull emanating from a pale passive invalid in the bedroom. Only after a tremendous struggle was he able to break the spell and save himself from being drawn in there. Here the Regressed Ego is 'pulling' the Central Ego down into itself and success would mean breakdown into illness such as this patient had already experienced

once. But the other aspect of the situation was revealed in a dream of the same patient during his earlier illness. He dreamed that he was driving a peculiar car, which was closed in with no proper outlook on his side. In the passenger seat was another man with a definite personality who could see out more clearly. The dreamer who was 'driving blind' felt that they ought to have been somewhere else taking part in some activity that involved duties and responsibilities but he was gleeful that they were not and he was driving away taking the other man with him. Here the Regressing Ego is sweeping the Central Ego away out of the pressures of active life in a determined but blind drive into oblivion and passivity, i.e. breakdown. Just as the first dream represents a successful later effort to resist another breakdown into illness, the second one represents the original breakdown in full career.

Once the Regressed Ego feels to have reached its goal of retreat deep inside the hidden, womb-like state of the deepest unconscious, the Central Ego seems to have little success in drawing it out again. Thus an unmarried woman in middle life dreamed that she was watching a child-birth, but the baby could not be got out. Its head emerged but then it stuck fast, and even ropes tied on to it and passed through the window and fastened to horses who were driven to pull failed to drag it out. This patient was telling herself that she could not force her Regressed Ego to a rebirth. In this state some patients manage to carry on routine living in a de-emotionalized, cold, mechanical way. This patient felt exhausted with the fight to keep her Central Ego functioning. Some patients exhibit more the determined drive backwards into regression or the pull of their Regressed Ego on the rest of their personality, others give the impression that a part of their personality has for long been inaccessible and hidden away quite out of touch with outer life. I am inclined to feel that in every case there is a deepest part of the original ego split off and hidden in a state of regression, corresponding to what Winnicott calls the 'true self' hidden away in safe storage to await

a favourable chance of rebirth. The more active phenomena of the 'pull and drive' to regression may represent the conflicts set up in the psyche over the effects on the whole, of the existence of a profound Regressed Ego originating in very early life. This creates, from the point of view of external living, a struggle between longings for, fears of, and resistances against breakdown. The 'struggle to preserve an ego' has two aspects: the struggle to preserve the Central Ego of everyday life from being undermined by regression, and the struggle to preserve the basic Libidinal Ego, the core of the personality, from being crushed by overpowering outer reality or lost irretrievably when it withdraws deep within out of reach of being hurt.

This latter aspect of the problem emerges in tragic self-contradictoriness in the problem of schizoid suicide. The longing to die represents the schizoid need to withdraw the ego from a world that is too much for it to cope with. Whereas depressive suicide is the result of an angry destructive impulse, schizoid suicide is the result of apathy towards real life which cannot be accepted any longer. All available energy goes into a quiet but tenacious determination to fade out into oblivion, by means of gas, hypnotic pills or drowning. One patient expressed the longing to die at a time of great stress and I suggested that what she wanted was not destruction, non-existence, but escape into warmth, comfort and being almost but not quite unconscious. She said 'That's it; just conscious enough to be aware of being warm and safe', like having gas at the dentist's to escape pain, which appeared to her 'like a very pleasant way of dying'. Unfortunately, in practice, more is achieved than is intended and the patient may die.

2. *The need to save the ego by internal object-relations.* Once the fear-dictated retreat from outer reality has been set up, the schizoid individual has two opposed needs both of which must be met unless death is to supervene; the need to withdraw from intolerable reality and the need to remain in touch with it, to save the ego in both cases. This is what enforces the

final ego-split into an active suffering and a passive regressed Libidinal Ego. The flight into regression begets a counter-flight back into object-relations again. But this return to objects must still compromise with fear and the need to remain withdrawn, and this leads to the creation of an object-world that enables the ego to be both withdrawn, yet not 'in the womb', the Kleinian world of 'internal objects,' dream and phantasy, a world of object-relationships which is also withdrawn 'inside' out of the external world. This, *par excellence* is the world of psychoneurotic and psychotic experience. Sometimes the flight back from deep regression to objects in the sense of 'internal objects' appears to go further and become a return to the external world itself. But close inspection shows this to be illusory. It is not a return to the actual reality of external objects as such in their own right, but a projection on to them of the internal world of phantasy objects, which accounts for the unrealistic reactions of psychotic and psychoneurotic patients to real people. Living in the internal phantasy world and the projected phantasy world both constitute a defence against loss of the ego by too complete regression and depersonalization, while remaining in varying degrees withdrawn from external reality which is still felt to be hostile.

This type of defence, however, has its own dangers. Over and above the ultimate danger of ego-loss by schizoid depersonalization, there are three further dangers of ego-loss that arise in this mid-region of defensive activities. The flight back to objects is at first a return to the bad objects from whom escape was originally sought. Bad object-relations at first safeguard the separate identity of the ego by setting it in clear opposition to its object, a defence much used. The frightened person becomes quarrelsome, but this may go too far and get out of control, mounting up to persecutory anxiety in the inner world and the schizophrenic fear of being torn to pieces. There appear to be two ways of escape from this schizophrenic terror of disintegration of the ego under persecution by internal bad objects or under the pressures

of real life experienced in the internal persecutory set-up. The flight to good objects gives rise to another perilous situation for the ego. The basic attitude to good objects is already fixed as a panic-stricken flight inside for safety. Even short of that, the relation to a good object is so much one of fear-enforced infantile dependence that it feels smothering, as already noted. Thus *claustrophobic* anxiety arises, to be distinguished from the schizoid fear of ego-loss by depersonalization, the typical state to which the Central Ego in touch with the outer world is reduced when all vitality has been drained out of it by too complete regression. This could lead to death and total ego-loss. The claustrophobic fear of being stifled by being shut in is the price to be paid for seeking safety through flight back inside. The active ego is in danger of being lost by reduction to a state of passivity in which no self-expression is now possible.

Thus *no objects* involve the fear of ego-loss by depersonalization, *bad objects* involve the fear of ego-loss by disintegration under destructive persecution, *good objects* involve the fear of the loss of the active ego by imprisonment in smothering passivity. One further possibility remains, a compromise between bad and good objects. If one hates good objects instead of bad ones, there will not be the same danger of retaliation by the object and also smothering is avoided. But now a fourth danger appears. If one hates a good object the ego feels fear, not primarily for itself but for the object. Guilt will arise and with it Mrs Klein's 'depressive anxiety' in place of the more primitive 'persecutory anxiety'. *Ambivalent object-relations* involve fear of loss of the ego for all practical purposes through the paralysis of depression, in which state the ego dare not do anything at all for fear of doing wrong. The good object becomes an accusatory object and the ego feels morally persecuted. We may thus grade the dangers to which the ego feels exposed. The ultimate and worst danger is that of total ego-loss, represented in consciousness by depersonalization, and by such profound apathy through schizoid withdrawal and re-

gression that death would ensue. Against this danger the defence of resort to bad object-relations tends to over-develop, and leads either to schizophrenic terror of disintegration under violent persecution, or depressive paralysis under merciless accusation and pathological guilt. Nevertheless these two psychotic dangers arise out of the operation of the defence of bad object-relations against the ultimate schizoid danger.

With the claustrophobic anxiety of being shut in and stifled in good object-relations we ascend to the level of what Melanie Klein and Fairbairn agree to regard as the defence of psychoneurosis against psychosis. Thus the claustrophobic fear of being stifled is the least virulent danger to which the ego is exposed. Its overcoming, so that good object-relations can be accepted without fear, even when in order to secure the rebirth of the deepest Regressed Ego they must involve a measure of passive dependence at first, is the obvious line of advance to the psychotherapeutic goal. This complex situation in its entirety is illustrated in the early sessions of a patient who, prior to analysis, had suffered a paranoid-schizophrenic illness. During the opening sessions she oscillated violently between hopes and fears concerning myself. 'You'll let me down, you'll walk out on me, you don't feel any real concern about me, you'll tell me my attitudes are all wrong'; or else, in defence against her fears, 'I hate you, I feel furious with you, I could murder you', and then at other times 'When I come here I'm numb, I can't feel anything'. It was a sign of progress when, after two months, she could say: 'The other night I felt you did care about me and I was near to tears.' This was soon followed by 'I feel I hate you and myself when I think I creep and crawl to you and depend on you'. Here are the serious difficulties of an utterly insecure ego rushing from one kind of relationship (in the transference situation) to another more in the hope of escaping dangers than of finding security. The inner situation is brought out plainly in her dreams at this time.

Dream 1. 'People were pushing into my

room and I was trying to keep them out. Then I rushed out into a church, flung myself at the feet of the Mother Superior and asked to enter a convent.' Here is a powerful regressive flight from bad objects (especially a persecuting father) into the maternal womb and the practical danger of an undermining flight from life. To counteract this she turns the good mother, who in being a refuge might swallow up her personality, into a bad object with whom, by antagonism, she can maintain her separateness. Thus in *Dream 2*: 'I was with mother in the bedroom and got furious. She said "You can go to bed". I said "I can do that any time"'. Then she was on a bike coming at me. I pulled her on the ground and said "There, enjoy your masochistic pleasures"'. But this hate of her good object frightened her, for in a *third dream* she excluded herself altogether from the good protective situation. 'There was a party at my Minister's house. I wanted to go but was not invited. I rushed in hoping not to be noticed but his wife saw me and said "You've not been invited. You can't stay." I was in despair.' But rather than have no objects at all, and having run into difficulties with both good and bad ones, she turned in *Dreams 4 and 5* to ambivalent morally persecutory situations. 'I was bending over waiting to be caned', and more explicitly 'Mother and father were smiling and arranging for me to be beaten. I felt "Oh! well, its belonging to home anyway"'. She mentioned that in a previous treatment with a psychiatrist she had attacked him to make him control her forcibly, 'like Daddy did'. This patient would say at various times: 'Whichever way I turn, I feel there's no way out.'

THE PSYCHOTHERAPY OF THE REGRESSED EGO

This article deals with diagnosis, not treatment, and only a brief word can be said about psychotherapy. Usually, it is a very long time before the patient can consistently accept and bring to the analyst the regressed, passively dependent ego. The analysis of antilibidinal reactions against not so much active as passive

final ego-split into an active suffering and a passive regressed Libidinal Ego. The flight into regression begets a counter-flight back into object-relations again. But this return to objects must still compromise with fear and the need to remain withdrawn, and this leads to the creation of an object-world that enables the ego to be both withdrawn, yet not 'in the womb', the Kleinian world of 'internal objects,' dream and phantasy, a world of object-relationships which is also withdrawn 'inside' out of the external world. This, *par excellence* is the world of psychoneurotic and psychotic experience. Sometimes the flight back from deep regression to objects in the sense of 'internal objects' appears to go further and become a return to the external world itself. But close inspection shows this to be illusory. It is not a return to the actual reality of external objects as such in their own right, but a projection on to them of the internal world of phantasy objects, which accounts for the unrealistic reactions of psychotic and psychoneurotic patients to real people. Living in the internal phantasy world and the projected phantasy world both constitute a defence against loss of the ego by too complete regression and depersonalization, while remaining in varying degrees withdrawn from external reality which is still felt to be hostile.

This type of defence, however, has its own dangers. Over and above the ultimate danger of ego-loss by schizoid depersonalization, there are three further dangers of ego-loss that arise in this mid-region of defensive activities. The flight back to objects is at first a return to the bad objects from whom escape was originally sought. Bad object-relations at first safeguard the separate identity of the ego by setting it in clear opposition to its object, a defence much used. The frightened person becomes quarrelsome, but this may go too far and get out of control, mounting up to persecutory anxiety in the inner world and the schizophrenic fear of being torn to pieces. There appear to be two ways of escape from this schizophrenic terror of disintegration of the ego under persecution by internal bad objects or under the pressures

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gression that death would ensue. Against this danger the defence of resort to bad object-relations tends to over-develop, and leads either to schizophrenic terror of disintegration under violent persecution, or depressive paralysis under merciless accusation and pathological guilt. Nevertheless these two psychotic dangers arise out of the operation of the defence of bad object-relations against the ultimate schizoid danger.

With the claustrophobic anxiety of being shut in and stifled in good object-relations we ascend to the level of what Melanie Klein and Fairbairn agree to regard as the defence of psychoneurosis against psychosis. Thus the claustrophobic fear of being stifled is the least virulent danger to which the ego is exposed. Its overcoming, so that good object-relations can be accepted without fear, even when in order to secure the rebirth of the deepest Regressed Ego they must involve a measure of passive dependence at first, is the obvious line of advance to the psychotherapeutic goal. This complex situation in its entirety is illustrated in the early sessions of a patient who, prior to analysis, had suffered a paranoid-schizophrenic illness. During the opening sessions she oscillated violently between hopes and fears concerning myself. 'You'll let me down, you'll walk out on me, you don't feel any real concern about me, you'll tell me my attitudes are all wrong'; or else, in defence against her fears, 'I hate you, I feel furious with you, I could murder you', and then at other times 'When I come here I'm numb, I can't feel anything'. It was a sign of progress when, after two months, she could say: 'The other night I felt you did care about me and I was near to tears.' This was soon followed by 'I feel I hate you and myself when I think I creep and crawl to you and depend on you'. Here are the serious difficulties of an utterly insecure ego rushing from one kind of relationship (in the transference situation) to another more in the hope of escaping dangers than of finding security. The inner situation is brought out plainly in her dreams at this time.

Dream 1. 'People were pushing into my

room and I was trying to keep them out. Then I rushed out into a church, flung myself at the feet of the Mother Superior and asked to enter a convent.' Here is a powerful regressive flight from bad objects (especially a persecuting father) into the maternal womb and the practical danger of an undermining flight from life. To counteract this she turns the good mother, who in being a refuge might swallow up her personality, into a bad object with whom, by antagonism, she can maintain her separateness. Thus in *Dream 2*: 'I was with mother in the bedroom and got furious. She said "You can go to bed". I said "I can do that any time"'. Then she was on a bike coming at me. I pulled her on the ground and said "There, enjoy your masochistic pleasures"'. But this hate of her good object frightened her, for in a *third dream* she excluded herself altogether from the good protective situation. 'There was a party at my Minister's house. I wanted to go but was not invited. I rushed in hoping not to be noticed but his wife saw me and said "You've not been invited. You can't stay." I was in despair.' But rather than have no objects at all, and having run into difficulties with both good and bad ones, she turned in *Dreams 4 and 5* to ambivalent morally persecutory situations. 'I was bending over waiting to be caned', and more explicitly 'Mother and father were smiling and arranging for me to be beaten. I felt "Oh! well, its belonging to home anyway"'. She mentioned that in a previous treatment with a psychiatrist she had attacked him to make him control her forcibly, 'like Daddy did'. This patient would say at various times: 'Whichever way I turn, I feel there's no way out.'

THE PSYCHOTHERAPY OF THE REGRESSED EGO

This article deals with diagnosis, not treatment, and only a brief word can be said about psychotherapy. Usually, it is a very long time before the patient can consistently accept and bring to the analyst the regressed, passively dependent ego. The analysis of antilibidinal reactions against not so much active as passive

libidinal needs, constitutes, I believe, the most important part of 'analysing'. I have seen real improvements appear and be retained when what Winnicott calls 'therapeutic regression' at last comes to be understood and accepted. I sought to explore the difficulties of arriving at that constructive stage in my paper '*Ego-Weakness and the Hard Core of the problem of Psychotherapy*' (1960). This approach to therapeutic analysis shows that the cause of trouble is not to be found in the vicissitudes of separate instinctive drives which operate in antisocial ways, but in the basic weakness of the infantile ego perpetuated in a fear-ridden state. Infantile fear, regressive flight from reality and resulting ego-weakness in the face of the real outer world are at the bottom of all personality disorders. Our natural impulse-life is not normally antisocial but becomes such through the forced self-assertion and even violence of an antilibidinal attempt to over-compensate weakness. Our greatest need is to understand more about the earliest stages of strong ego-development and of the ways in which it can be prevented, or promoted.

The hope and possibility of the rebirth of the regressed ego is the obvious final problem raised in the interests of psychotherapy. I cannot see that we know very much about it as yet. Winnicott has opened a pathway that

many research workers will tread before the problem is mastered. I hope to be able to report clinical data on this matter. At this stage I feel only able to say that I have found encouraging results with several patients who each in his or her own different way, have been able to find security for their Regressed Ego in the psychotherapeutic relationship. There appear to be two aspects of the problem. The first is the slow growth out of their antilibidinal (Freudian sadistic super-ego) persecution of themselves; they need to unlearn their ruthless driving of themselves by ceaseless inner mental pressure to keep going as 'forced pseudo-adults' and to acquire the courage to adopt more of the understanding attitude of the therapist to the hardpressed and frightened child within. Simultaneously with this there goes on a second process, the growth of a constructive faith that if the needs of the Regressed Ego are met, first in the relation to the therapist who protects it in its need for an initial passive dependence, this will mean not collapse and loss of active powers for good and all, but a steady recuperation from deep strain, diminishing of deep fears, revitalization of the personality, and rebirth of an active ego that is spontaneous and does not have to be forced and driven; what Balint calls 'the new beginning'.

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Observations on the psychotherapy of puerperal breakdown

By PETER LOMAS*

In previous papers, based on a series of cases treated at The Cassel Hospital (Lomas, 1959, 1960*a*, *b*), I described certain factors found to contribute to the aetiology of puerperal breakdown. In this paper I shall describe in some detail the psychotherapy of two of these cases, discuss the roles of the therapist and of the hospital, and attempt to formulate some of the goals which would seem to be within the reach of treatment.

The mothers were treated as in-patients and were encouraged to bring their babies with them—an offer which most of them accepted. Others, being quite unable to tolerate the presence of their babies, declined at first, but brought them in as treatment progressed. One or two never achieved this reunion. In some cases husbands also came to the hospital for week-ends. Owing to the environment in which these patients were treated, acute, unmanageable psychosis had to be excluded. Treatment was by individual psychotherapy based on psychoanalytic principles.

Puerperal breakdown is not a well-defined clinical entity. The illnesses of these mothers fell into a variety of categories from the point of view of descriptive psychiatry: depression (either neurotic or psychotic), schizophrenia, hysteria, anxiety state, and mixtures of these syndromes. Cutting across these classifications was an inter-personal pathology: a disturbance of the mother-child relationship to an extent that was damaging to the child (if not so obviously to the mother). In short, these mothers could look after their babies either very unreliably or not at all.

CASE 1

Mrs R. was admitted to The Cassel Hospital with her 11-month-old baby boy. Although she

had never been psychiatrically ill before, she became acutely confused three days after the childbirth, with the result that she was sent to a mental hospital and given a course of electroconvulsive therapy. On returning home she continued to act and talk in a strange way and was unable to tackle her household duties though she managed to look after the baby. She had a further course of E.C.T. without gaining improvement and, a few weeks before her admission to The Cassel Hospital, ran away from home in the middle of the night wearing her husband's clothes and having cropped her hair.

Her general practitioner, who was concerned at her manifestly psychotic behaviour, had advised her against bringing her baby to hospital, but in spite of this she arrived at the Cassel Hospital with the baby and an unspoken demand that he be accepted too.

Her appearance was striking. She was a good-looking woman whose close-cropped hair and staring, dreamy eyes made one think of Joan of Arc. During sessions she talked for the most part like a playful, teasing child, and much of her inconsequential chatter displayed primary process thinking. Among these thoughts were references to men, whom she despised and hated, to frightening machines, to 'big dams bursting', and self-accusations for 'stealing knives', for not being feminine, for not washing her hands, and for not loving her baby or her husband. She took a delight in quoting verses of Edward Lear and Lewis Carroll—in particular, Old Father William who stands on his head 'although I fear it might injure the brain, but now I am perfectly sure I have none, why I do it again and again'. Often her quotations could be seen to be slyly malicious comments about the (male) therapist.

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In complete contrast to her usual irresponsible chatter she talked of her baby, Timothy, with sanity and with real feeling and was quite obviously devoted to him.

In the hospital she was encouraged, in common with the other mothers, to look after the baby and this she did with the utmost care and patience. Timothy was her life and she had little time or capacity to attend to anything else. She was very indulgent towards him and allowed him to make a dreadful mess. In this she identified with him, for she herself was extremely untidy, although not to the extent of being dirty. It was also noticeable how she and the baby looked like each other. There were no rows between them, he never was known to cry, and everyone agreed that he was a singularly beautiful baby, even though he was rarely responsive.

During sessions her hate and contempt of men became more blatant. 'I'll tell you a tale that I told to another patient who believed it', she said, with gleeful mockery. 'I told her that I was a Mormon who had six husbands. I went shopping on a Yak and my chief husband walked behind. I left the other five at home to do the washing up.' She aroused in the therapist a tendency to treat her as an irritating yet amusingly mad child who needed humouring. Before long she spotted his reaction and it became clear from her associations that she resented it. The interpretation was made that she needed to be such a foolish and mad child because she was terrified of being taken seriously, yet felt bitterly angry that she had to act in such a way. Her anger caused her to be all the more foolish and confusing in order to induce a similar despair in the therapist. This interpretation was, unlike nearly all others made, listened to seriously and acted upon, and she became more coherent afterwards.

She was clearly very proud of Timothy, but at first reluctant to admit this. Later she said 'I think he is perfect and other mothers' babies are...', leaving the sentence unfinished. 'But it is not good form to go strutting about the place.' It seemed that all her hopes and ideals, especially her masculine wishes, had been pro-

jected on to the baby, perhaps to delusional intensity, and that she had surrendered her life masochistically to him. This sacrifice of herself went as far as relinquishing her social claims and adult status, as though she felt that if she were not taken seriously then she would be allowed to enjoy the baby. This masochistic surrender was unstable, for she felt vicious hatred towards males, and in order to avoid feeling hate towards her baby she made her main target her husband and, later, the therapist. The figures of her childhood remained colourless and unreal, particularly that of her mother. Her father she described as 'stuffy and pompous', yet she obviously admired him. She was the middle of three sisters, felt that her parents would have preferred a boy, and greatly envied her elder 'brilliant' sister. However, it seemed particularly difficult for her to relate interpretations in a meaningful way to her childhood, and at most she would feel diffusely that she had been unloved and misunderstood, but could not remember this in any detail. It also became gradually clearer how, in spite of the satisfaction derived from her baby, she felt desperately empty and unwanted. 'I don't know why I came, or why I come' she said. 'I can't go home. My husband wouldn't let me.' (This was not overtly true.) Her intense envy of men became clearer, and she began to talk of her actual problems with her husband; of how she used to play a major part in the financial affairs of the family because she was so much more efficient than him, but now she can't do it, nor can she drive the car; of how lucky he is, like all men, how pompous, how useless. She became upset at the thought that their sexual life was unsatisfactory, and berated the therapist for not helping them.

After she had been at hospital five months she attempted suicide by taking aspirin tablets. For several days prior to this she had been depressed, but the actual precipitating cause was a rebuff by the therapist who made a mistake over her session time. Her suicidal attempt brought the response of real, yet angry concern on the part of the staff and she

expressed her anger in return. In the following session the therapist also expressed both anger and concern. The suicidal attempt was interpreted as an attack on the therapist due to feeling rejected, a means of finding out if he was really concerned about her, and a desperate attempt to convey to him how ill she was—in the only way she could. The impression gained was that she was pleased by, and grateful for, our reaction to her suicidal attempt.

Following this episode there was a considerable clinical improvement. She looked better, took part, often quite prominently, in social activities and even went out for one or two evenings to enjoy herself, leaving someone else to look after Timothy. There was also a change in Timothy, who began to show signs of aggression for the first time.

Soon after this she learnt that her younger sister had given birth to an illegitimate child, and commented bitterly on not having been told of this and on her parents' unsympathetic treatment of her sister. She therefore went to visit her sister and identified herself closely with her, recalling her own feelings of shame at the time of childbirth. Indeed, it seemed to be a feeling of shame which had hitherto prevented her from talking about the childbirth and puerperium. She felt ashamed of her failure to stand up to the test and bitter towards her medical attendants for not having enabled her to do so. In recalling these experiences she said: 'I'm no good as a woman. I'm not fit to be a mother.'

At this point, unfortunately, the therapist left the hospital staff, and during the final phase of the relationship her aggression towards him reached its maximum. His date of departure was delayed by a month, and this the patient could not tolerate because she felt it was being done to confuse her. Her fear of being confused was discussed and she became very angry. This time, however, she expressed her anger openly, demanded an immediate change of therapist (to a woman) and stormed out of the session. Following this, her paranoid fears of being confused diminished and she

reported in the next session that she no longer believed particular magazines were deliberately put in the waiting room in order to upset her. She was also able to talk for the first time about her feelings of anger towards Timothy. 'I am afraid of terrifying him', she said, 'but perhaps he is tougher than I think.' This seemed to be a reaction to experiencing that the therapist was tougher than she thought and could take her direct expression of anger in the previous session.

The decision was made that she would remain in hospital in the care of another therapist, and although it was feared that this might totally disrupt the improvement hitherto made, the transition proved to be less traumatic than had been expected. This was perhaps due to close collaboration between the therapists, to the support of the hospital environment, to her relationship with the sisters and other patients, and to the continuing success of the mother-child set-up. She gradually became more realistic, able to recognize the therapist as a separate being with his own life to lead, and she returned home eighteen months after admission. We felt a certain amount of concern for the development of her child because of the intensity of the mutual identification and lack of overt aggression between them.

Owing to this patient's relative inability to discuss her early life, and to her confused state during the following childbirth, it has not been possible to make a very satisfactory reconstruction of her psychopathology. The essential features of her illness, in so far as they were understood, would seem to be as follows. Although never mentally ill up to the time of the childbirth she could not have been described as well-adjusted; in her own eyes she was an outsider, a wayward person, a kind of tramp, and a permanent misfit. Her chief defence had been a detached and ironically playful attitude to life, which she had never taken quite seriously. She had not made a satisfactory sexual adjustment, having too great a masculine identification and envy of men.

Childbirth proved to be a painful and humiliating process, and in retrospect she angrily berated her medical advisers, particularly her doctor, at the same time maintaining that they were very kind. It was at this crisis in her life that her detached, yet organized attitude to the world had broken down, and her rage emerged in a dissociated way—directed primarily towards men. It seems likely that childbirth caused her envy and hate of men to reach breaking point, because she experienced it as a castration. A consequence of this was her desperate attempt to reassert her masculinity by cropping her hair and dressing up as a man.

It is not sufficient to describe her experience of childbirth as a castration, in the sense of a loss of masculinity, for her resultant feeling was one of complete emptiness and loss of her sense of identity. That loss of identity (or, subjectively, of 'ego-feeling') is the essential feature of schizophrenia has been suggested by Federn (1952), and more recently by Freeman, Cameron & McGhie (1958). Although castration becomes a more sufficient term if the phantasy of 'body-phallus' is present—as it was in Mrs R.'s case—the sense of identity involves more than the awareness of the body, and is intimately related to the ego-ideal (Erikson, 1956). Mrs R.'s picture of herself had collapsed utterly under the impact of childbirth and she felt bitterly ashamed.

Lynd (1958) has called attention to the close relationship between feelings of shame and loss of identity. She describes shame as the loss of trust in expectations of oneself and of other persons, as opposed to guilt which is a transgression of a code. As an example of shame she cites the feelings of a small child who had carefully planned a surprise present for a loved adult who failed to appreciate it. Similar experiences are the lot of a mother who has idealized her baby, and Winnicott (1948) has described the feeling of disillusionment in the new-born baby as being an important factor in the mother's hate for the child.

Mrs R. acted out these feelings symbolically by bringing pathetically messy and more or less illegible 'essays' (representing her genital, her

baby, and her confused self) to the therapist and being very interested in what he thought of them.

Mrs R. was a mother but nothing else. In becoming this she was no doubt responding to a biological urge, but was also compensating for her loss of ego-feeling by identification with the baby who was idealized. This relationship was the thread by which she maintained her hold on reality, and the baby served the purpose of a transitional object or fetish. The willingness to sacrifice herself for the child is in keeping with the schizophrenic's willingness to sacrifice maturity and social development for the fulfilment of a primitive wish. A mother with a character disorder is often faced at childbirth with the unhappy choice of either maintaining her defences, at the expense of a failure of empathy with the baby, or a pathological breakdown of defences in an attempt to feel empathy. Mrs R. chose the latter, if choice it can be called. As the disruption of personality was not such as to break up the mother-child relationship entirely, she found it easier than most women to be an indulgent mother and could allow her baby to make such a mess as would have driven another mother crazy. There were, however, disadvantages in her maternal capacities. Owing to her intense identification it was difficult for the baby to develop a personality of his own, and he looked remarkably like her. Moreover, owing to her own lack of aggressiveness, he did not learn (or dare) to be aggressive himself. In spite of her idealization of the baby, her relationship with him was on a much more mature level than were her dealings with others, and she showed real love and concern for him.

In her relationship with the therapist she showed a mixture of identification and rejection. Her transference was that of the psychotic who has a desperate hunger for objects with whom to identify, coupled with an acute sensitivity to any lack of interest, and a tendency to reject the object angrily and violently. Perhaps the greatest demand made by this patient was to be recognized, and it was following recognition, or interpretation con-

cerning recognition, that clinical improvement occurred. It was very important indeed for her that her baby was recognized, but that was not enough. She needed to be recognized herself. What this patient seemed to be doing, following the loss of identity imposed on her by childbirth, was attempting to establish a true sense of self by being recognized as a real person while at the same time maintaining some sort of pseudo-identity by identifying herself in an unrealistic way with the baby, the therapist and the hospital.

CASE 2

Several years earlier, Mrs E., now 31, had developed acute anxiety about her duties as a midwife and had become a drug addict. Her first child, a girl now two years old, had been in a residential nursery since a few months old when the patient had resorted to drugs to an extent considered dangerous to the child, and had herself been admitted to a mental hospital. Mrs E. was referred to us from the mental hospital when she was seven months pregnant with her second child, because the referrer felt she might stand a better chance of keeping her baby if she came to The Cassel Hospital after her confinement.

After a normal confinement in a maternity hospital she went home, and at first felt there was no need for her to come to hospital. Soon, however, she became acutely anxious, found the responsibility of her house and the baby boy to be more than she could bear and asked to be admitted.

Mrs E., slight and quietly feminine, came to the first interview in a state of profound depression and sat meek and passive, as though waiting for judgement to be passed on her. When, after encouragement, she began to speak, it was of her feeling of utter uselessness as a wife and mother, her fears of the responsibility for the baby and her doubts as to whether she and the baby would be able to fit in with hospital life. She remained in this depressed state throughout the fortnight's assessment period, and the therapist, affected by her intense feeling of helplessness and the know-

ledge of her addiction to drugs, felt very doubtful of the wisdom of attempting to keep mother and baby together.

It soon appeared that some of her despair derived from the fact that she felt quite sure we would not keep her on for treatment and would assuredly send her back to the mental hospital, regarding her as unfit to look after her baby. She also knew that she had no chance of looking after the child on her own at home, and would, in her anxiety, again resort to drugs. When it was agreed that she should stay on as a patient, together with her baby, she showed great relief and gratitude, and from that moment her demeanour changed. The therapist's fears that an improvement based merely on another's belief in her maternal capacity would not be maintained by such a sick patient were gradually allayed as she began to show a great determination to sort herself out, as well as a pursuit of truth that is rather rare.

The main theme of interpretation was that she had repressed most of her aggression towards her possessive mother (and more recently her husband who organized her household activities as though she were a child) and that this was now hidden behind a masochistic need to placate others and abase herself. It gradually became possible to show her this in the transference. She had an enormous respect for doctors, and treated the therapist as though he were a god, attempting to please him in every way, but this was in part an aggressive attitude, for she thereby concealed herself from him and deprived him of an alive and human relationship with a real person. Following this understanding her tense and reserved demeanour during sessions slowly became replaced by an increase in directness of emotional expression towards the therapist. Although her earnest co-operation still contained an element of conformity she had a genuine urge to recovery which made real work possible.

Mrs E.'s self-destructive flight into drug taking (which had made her unable to look after her first baby) had not only been an escape from responsibility, but also a surrender

of her own life and her own wishes to other people whom she compelled to deprive her and discipline her. This masochistic urge had caused her to act in such a way that she was sent to a mental hospital, leaving her baby in the hands of her mother. This act was a condensation of her need to surrender her most loved possession to her mother (whom she had always felt was envious of her) and a revengeful desire to attack her mother (and the world in general) by ridding herself of the anxiety-causing child with whom she was identified, and leaving the burden of his care to others. In taking her into hospital with her baby we had not only, by implication, shown our belief in her as a mother, but in her loveliness as a child. Unlike her, we were unafraid of infantile anxiety and hate. This now enabled her to look after her own baby.

The envy which Mrs E. feared from her mother was based not only on a projection of her own feelings of hate and envy, but on historical fact. Her mother, a most dissatisfied woman, had contracted an unhappy marriage which ended in divorce when the patient was 15. Even as a child the patient remembers feeling sorry for her mother, who cut a rather pathetic figure in her attempt to remain young to keep pace with her, and who was terrified of ageing. Mrs E. had grown up afraid of her own femininity, afraid to tell her mother when she first became engaged, and when she was first pregnant. She was afraid, too, of showing her feminine capacities and of asserting herself as the woman of the house towards a husband who took on domestic responsibility and acted rather like the woman of the house himself.

Mrs E., although inwardly angry about being deprived of her function had never before been able to assert herself in this way. Now she began to do so. She became more forcible in her marital relationship, and took to going home at week-ends and controlling domestic affairs. She was no longer awed by her husband's managerial capacities. While in hospital she looked after her baby boy conscientiously and well, although tending to worry excessively about his health and being

unable to take an open pleasure and pride in him. One major source of her distress was the shame and guilt she felt about her failure with her first child who had remained in the residential nursery and whom she visited occasionally. She would break into tears when talking of her. The interpretation was made that she was identified with this baby girl whom she had needed to destroy, just as she had now masochistically destroyed her own life. A few months after her treatment began she decided that she had become capable of looking after the little girl and that she wished to do so. She took her from the residential nursery and brought her to stay at the hospital. This girl was backward, probably because of her long motherless stay in an institution. She was withdrawn and presented an immense therapeutic problem to the mother who, however, responded with patience and understanding.

As treatment continued she showed increasing assertion towards the therapist and began to fear that he was possessively using her for his own ends. This could be seen as a repetition of her feelings towards her mother. The feeling that she was being constricted by the therapist's own needs, and her desperate desire to be free and to be herself, represented a recurring theme which was the crucial one in her therapy. Because of this the decision of when she would go home was left as far as possible in her hands, and she made it without hesitation at the end of ten months' treatment. Whether this was wise is perhaps difficult to say, for serious sexual difficulties had not been resolved, and her decision to stop treatment undoubtedly contained a defensive element. Nevertheless, it was felt that her capacity for real maternal feeling had been established, and that this decision to return home was an expression of it.

DISCUSSION OF THE CASE HISTORIES

The two cases described above showed marked differences in psychopathology and symptomatology (as indeed did all the cases in this series) but certain similarities can be seen.

Both women had been unsure of their femininity before childbirth and both despaired of their maternal capacity afterwards, feeling themselves to be incapable of loving their babies. Neither woman could tolerate her baby's aggression. Although they both reacted differently to it, these mothers had much shame and first-aid measures were needed to counteract it. The only way to do this was by showing belief in them as mothers. This was done by taking them, with their babies, into hospital, where they received not only encouragement in their function of mothering but protection against their own violent feelings. When this need was met, individual therapy based on psychoanalytic principles became possible.

THE FUNCTION OF THE HOSPITAL

Bringing the puerperal mother into hospital together with her baby—a therapeutic manoeuvre described by Douglas (1956)—could be seen to have the following effects on the mother:

(1) She felt believed in as a woman and as a mother and she felt that her child was believed in.

(2) Any unconscious guilt she felt for bearing a child was relieved by the permissiveness of the hospital, which played a parental role.

(3) She felt protected from her own hostile impulses towards the baby (engendered by unconscious factors which will not be dealt with here).

(4) She could escape from the hostility and envy which, rightly or wrongly, she feared from her relatives, particularly women.

(5) She was eased from the burden of looking after her husband, a burden which several of these patients, owing to pathological husband-wife relationships, felt to be excessive.

(6) The hospital gave her the support which even a 'normal' puerperal mother, in her state of mental disorganization and reorganization, requires of her environment.

One disadvantage of bringing a puerperal mother into hospital is the consequent disruption

of important family relationships. This was prevented as far as possible in our series by allowing mothers who had older children to bring them into hospital and by encouraging husbands to visit whenever they could, and in some cases to live at the hospital, if only for week-ends. It seems likely that less sick mothers with good family relationships could satisfactorily and perhaps more profitably be treated as out-patients.

The effects of hospitalization described above could be expected, to some extent, as a consequence of taking the mother and child into a hospital. However, the hospital setting in which these cases were studied was particularly orientated towards mothers and children (Main, 1958). The mothers were treated not as sick and helpless patients, but as responsible people free to conduct their own affairs and having a say in hospital management, especially as far as arrangements for mothers and babies were concerned. Within this culture pattern the mothers could feel that it was taken for granted that they would be able to look after their children. There was no atmosphere of compulsion which those mothers in revolt against maternity as a symbol of feminine subjection or parental demands would resent. Moreover, each patient had a hospital Sister allotted to her to whom she could turn as a woman and mother-substitute. Opportunities for relationships with other mothers were plentiful.

The atmosphere provided is in striking contrast to that to which most mothers who are confined in hospital are exposed during the puerperium. This is not to suggest that the present-day maternity ward is the cause of puerperal breakdown, but in many of the mothers described (all of whom had hospital confinements) it was undoubtedly a contributory factor.

THE FUNCTION OF THE THERAPIST

The role of the therapist cannot be entirely separated from that of the hospital, for although his function is primarily to interpret the

patients' psychopathology, he is a member of the hospital staff. He decides, with the help of his colleagues, whether the patient will be taken on for treatment. By his tolerant attitude and his belief in the patient, he supplies her with the essential support previously described. His role as interpreter is also bound up with this function.

It is difficult to define a psychotherapeutic technique for the specific treatment of puerperal breakdown as it eludes clear definition as a clinical entity. However, it is perhaps useful to set down the tentative theoretical approach developed as a result of treating these mothers, and to describe some recurrent psychopathological themes which required interpretation.

Puerperal breakdown is a pathological reaction to new psychological experiences which are associated with childbirth. These experiences include changes in the body image, close contact with a primitive human being with whom identification is made, and alterations in other personal relationships, especially those of the family. This produces an identity-crisis (Erikson, 1956) characterized by a breakdown of the previous mental organization, both adaptive and defensive, and the need to make a new adaptation. In puerperal breakdown, owing to faulty emotional development in the mother and/or an unsatisfactory environment during the puerperium, this new adaptation cannot be made, resulting in anxiety, confusion, and the production of pathological defence mechanisms.

The following factors are important in producing this outcome (and require interpretation during therapy).

(1) The mother's identification of the baby's crying with her own primitive aggression, causing her to hate and reject him, and setting in motion a vicious circle of hate and guilt (cf. Szasz, 1959).

(2) Dissatisfaction with the feminine role, causing her either to reject maternity or to identify it with a phallic performance, thereby incurring feelings of guilt.

(3) Fear of the envy of others for her success-

ful creative act, for its social significance, for its unconscious meaning in terms of oedipal strivings, and the vicarious pleasure it brings in terms of primitive infantile enjoyment of life. Such fear of envy is augmented if the baby is idealized.

(4) Masochistic tendencies designed to ward off the envy of others and to counterbalance feelings of guilt.

THE AIMS OF PSYCHOTHERAPY

In thinking about puerperal breakdown it is necessary to decide whether one needs (a) to treat a sick mother who has symptoms which must be cured, after which she may or may not be able to look after her baby, or (b) to treat a relationship, namely the mother-baby unit, which has gone wrong. These patients were approached with the belief that the latter view is the more correct one.

It follows that the first and immediate aim of psychotherapy must be to help the mother over her crisis with the hope that she will be able to continue her function as a mother. This can be best done by giving her a suitable and stable environment in which she feels allowed and encouraged to be a mother, and by interpreting the most urgent anxieties connected with her possession of the baby. If this can be achieved quickly the vital mother-baby link can be maintained, and in many cases the maternal feeling will emerge. It is important to decide, in the case of extremely sick mothers, whether the baby's only hope of psychological survival is temporary or permanent separation of the partners. The dangers in making this decision lie in the fact that powerful emotions deriving from unconscious sources and affecting both doctor and patient may influence the result. However, by far the greatest danger lies in underestimating the mother's capacity if she is given a chance to reveal it.

Once the crisis is over, and the patient is able to look after her child, the main question is at what point to be satisfied with her recovery. The patients in our series could be

divided into three classes from the point of view of outcome:

(1) Those mothers who made a quick and stable recovery, their personalities returning to the state prior to childbirth, with its accompanying defence mechanisms—a result which gives immediate satisfaction but may lack prophylactic value.

(2) More severely ill patients, particularly those characterized by almost complete frigidity and intense envy of men, whose personality problems had been more clearly revealed by the childbirth, and who remained, despite all efforts at therapy, bitter and unhappy women. It usually became possible for such patients to return home and to look after their families, but life remained essentially without meaning for them.

(3) In some cases, either because the mother did not respond quickly and return to her normal equilibrium or because the disturbance had caused her to become dissatisfied with aspects of her personality, further psychotherapy was attempted. Following breakdown of defences, these could be re-organized in a different way. In mothers of this kind a real change in personality structure took place which showed itself both in the transference situation and in a changed pattern of family and social relationships.

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The single case in fundamental clinical psychological research

By M. B. SHAPIRO*

INTRODUCTION

There is no doubt that most clinical psychologists and psychiatrists, who are experimentally minded, believe that the single case cannot be used for purposes of fundamental research. This statement is amply confirmed by an examination of the current literature, particularly of the literature of experimental clinical psychology and experimental psychiatry. Perhaps the outstanding exception is that of Stephenson (1953) who, in his book, indicated quite explicitly the possibilities of research in the single case with human subjects. However, he does not appear to have gone on to realize these possibilities in the sense to be described in this paper.

There appear to be three conditions under which the single case can be used for research purposes in clinical psychology and psychiatry: the first is that of experimental control; the second is that of replication; and the third is that of the development of appropriate methods of measurement.

EXPERIMENTAL CONTROL

The phrase 'experimental control' implies that the conditions affecting variations in the appearance of a phenomenon in an individual case are well enough known to enable one to predict, in measurable form, the appearance of that phenomenon in situations which have never before been presented to that individual. The description of such conditions would amount, in effect, to the description of some of the laws affecting the phenomenon in that individual. Here is an example to illustrate the point (Shapiro, 1951). The phenomenon we

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are concerned with here is called the 'rotation effect'. It refers to the fact that many patients, when they do the block design test, leave their reproductions in a rotated position, though the design has been otherwise reproduced in an accurate manner (see Fig. 1). Taking advantage of some hints in the literature, an experiment was conducted upon a single case. One expectation was that the patient would rotate diamond-oriented designs and not rotate square-oriented ones. The findings were exactly opposite to expectation. The patient rotated the square-oriented designs, and did not rotate the diamond-oriented designs. Further examination of the data resulted in the realization that, by accident, each of the designs used was of diagonal symmetry (see Designs 4, 5, and 6 in Fig. 2). The line of symmetry is the imaginary line which divides a design into equal and perfectly mirrored halves, and in this case the line of symmetry coincided with one of the diagonals of each design.

The generalization then suggested itself that, in this subject, the angle of the line of symmetry and not the orientation of the design might be the operative factor in determining rotation, the patient always rotating when the line of symmetry was at an angle to the vertical axis of the visual field, and not rotating when it was parallel. To test this hypothesis a new set of designs was constructed, none of which had ever been presented to the patient before. In each of these designs, the line of symmetry, instead of coinciding with one of the diagonals, cut the design into two rectangles (see Designs 1, 2, and 3, in Fig. 2). It was argued that if the angle of the line of symmetry was the determining factor, then the patient ought now to rotate when the designs were in a diamond orientation and not rotate when they were in a square orientation. Thus it was predicted that

the relation of rotation to the actual orientation of the design would be reversed, the patient producing most of her rotations when presented with diamond-oriented designs, in contrast to the first experiment in which she had produced rotations mainly in response to the square-oriented designs. As a control, a design of diagonal symmetry was included in the second experiment. The results were con-

REPLICATION

The essence of the idea of replication is that, when one has confirmed a law in a single case, one then determines the degree to which the law can be found operating in other cases. In fact, seventy-eight other subjects were then tested (Shapiro, 1952, 1953). Each of these subjects was presented with the same set of

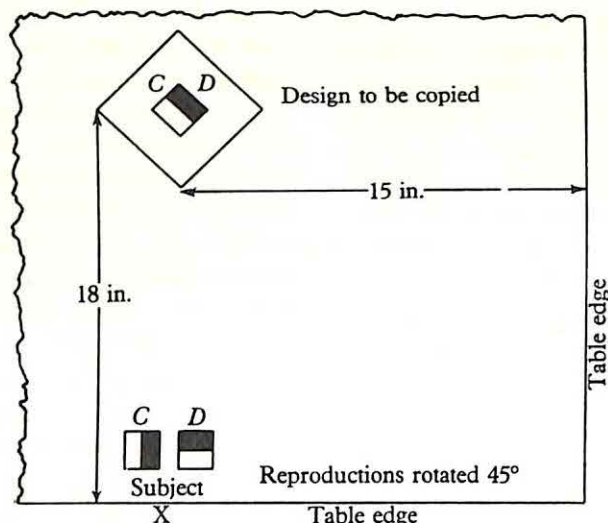


Fig. 1. The Rotation effect.

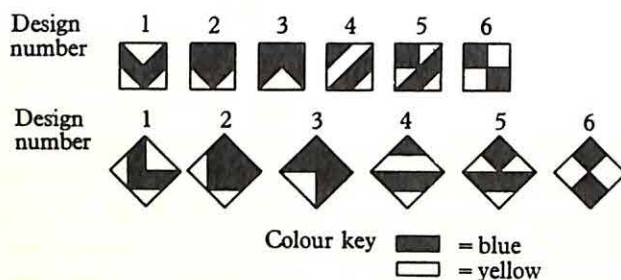


Fig. 2

sistent with expectations. It was possible to conclude, therefore, that a law had been discovered in relation to this particular patient's rotation; that is, a law concerning the angle of the line of symmetry. We had a law because we were able to operate it successfully with designs completely different in respect of the relation of the line of symmetry to the shape of the design.

designs, designs which were made to present various combinations of the two aspects of structure: in terms of the angle of the line of symmetry and in terms of whether the design was square-oriented or diamond-oriented. Among the outcomes of these studies were two which were relevant to our immediate subjects of discussion. First, the law concerning the angle of the line of symmetry was

clearly confirmed. All these subjects, taken as a whole, rotated far more when the angle of the line of symmetry was at an angle to the vertical axis of the visual field, as compared with the amount that they rotated when the angle of the line of symmetry was parallel to that axis. The second result was that, contrary to the finding on the first patient, there was also a powerful tendency for the amount of rotation to be increased when the designs were in a diamond orientation, and to be decreased when the designs concerned were in a square orientation. These two laws combined with each other to increase or decrease the amount of rotation.

These findings illustrate two general principles, which are regarded as essential in the use of the single case in fundamental research. In the first place, one would expect that the laws which enable one to achieve experimental control over a phenomenon in a single case would be found to operate in many other cases. The notion of 'experimental control' is used strictly in the sense defined at the beginning of the paper. The second generalization is that the failure to establish a law in a single case cannot be accepted as a failure until a considerable amount of replication has taken place. In the present case, the orientation of design was found to have no effect, yet it proved to be a powerful law in subsequent cases.

We cannot here discuss how these laws were used in the further investigation of the rotation effect. The reader is referred to a paper by Williams, Lubin, Gieseeking and Rubinstein (1956) for further developments.

FURTHER EXAMPLES

Another example of experimental control is provided by the work of Kohler & Wallach (1944) on what has come to be known as 'figural after-effect'. 'Figural after-effect' is a term which refers to the effects which can be produced by prolonged stimulation. In their first investigations, Kohler & Wallach experimented upon each other. They found that pro-

longed visual stimulation under conditions of fixation would produce, among other effects, a displacement of the percept away from the area of continuous stimulation. They found that they could manipulate this law to obtain predictable effects. For example, a stimulus could be made to look larger or smaller by appropriate manipulation.

As in the case of rotation, we cannot go into the theoretical implications of these findings. What matters to us in this discussion is that these effects have been confirmed by conventionally minded experimenters on large samples.

A third, and famous, example of work on the single case (drawn to the writer's attention by Miss I. Neufeld) is the work of Ebbinghaus upon memory. He carried out all his experiments upon himself. One of his generalizations which has stood the test of time is that of the logarithmic relationship between the percentage of material forgotten and the time elapsing after the original act of learning. This relationship was the outcome of very many experiments upon himself. No less than 163 are indicated by Woodworth (1947). His experimental control, in the strict sense of the word, presumably consisted of the fact that he could vary the period between the act of learning and the act of recall, and obtain the predicted degree of efficiency of retention. Woodworth remarks that many people doubted Ebbinghaus' logarithmic law because it had been obtained on the single case. However, subsequent work in the last half-century confirmed the law.

All these examples illustrate the proposition that the experimental control over psychological phenomena in one or two subjects will be confirmed in many other subjects. The establishment of experimental control means that one is beginning to manipulate the processes underlying the phenomenon which is being investigated. While a static single observation of a single static aspect of an individual's function may be unique and unrepeatable, being the outcome of an unrepeatable complex of determinants, the control of a process in any single organism, however

approximate, is probably repeatable in many other organisms.

EXPERIMENTAL CONTROL OF A CLINICALLY RELEVANT VARIABLE

The three examples which have been given of experimental control and subsequent replication are of limited interest to the psychiatrist and clinical psychologist. The question for the clinical psychologist is whether it is possible to carry out experimental investigations of the single case where the variable being manipulated has immediate clinical relevance. Examples of such variables are feelings of anxiety or delusions. The best example to hand, though a rather poor one, of an experiment on a clinically relevant variable is an experiment by Shapiro & Ravenette (1959). A patient with paranoid symptoms was the subject of this experiment. His beliefs were obtained from him in a series of interviews. It was decided to begin the investigation of paranoid symptoms by making a systematic investigation of the widespread belief that paranoid symptoms were not modifiable by rational discussion. To carry out this experiment it was decided to have two kinds of discussion: (i) rational discussions which were aimed at exposing the palpable falseness of the patient's paranoid beliefs; and (ii) control discussions concerned with some other topic of interest to the patient. His guilt feelings about a number of situations in his personal life were chosen as a topic for the second purpose as there appeared to be a rational basis, in his personal history, for quite intense guilt feelings. The discussions of the paranoid beliefs dealt mainly with their palpable absurdity. An example of an absurd belief was that there was an organization, with serious and conventional political aims, which spent an enormous amount of time and money following an ordinary citizen about and operating an elaborate system of microphones. The psychological mechanisms whereby a man of the patient's well above average intelligence could come to have such beliefs were also discussed. The control discussions of

guilt-feelings were concerned primarily with the general problems of forgiveness and condonement of misdeeds and anti-social behaviour. The aim here was to reassure the patient.

Table 1. *Statements of paranoid belief*

1. I believe that a minority group is secretly organizing a campaign against me.
2. I believe 'they' could be more powerful than any government or nation in the world.
3. I believe 'they' want to influence me.
4. I believe 'they' use microphones and electronic devices to keep a record of my every move.
5. I believe 'they' observe me everywhere I go.
6. I believe 'they' will keep watch over me in the future.
7. I believe that 'they' are trying to retard the growth of my children.
8. I believe that 'they' may be working to further eugenic ends, e.g. to eliminate an undesirable strain.
9. I believe 'they' are using methods of non-violence.
10. I believe that by a subtle use of the law 'they' have put me 'inside'.
11. I believe that I cannot escape from 'them'.
12. I believe that I am not the true father of my children.
13. I believe that my wife has been unfaithful to me.
14. I believe that I am not the son of my supposed parents.
15. I believe that one reason for 'them' getting at me is my pacifism.
16. I believe that one reason for 'them' getting at me is my failure as a man.
17. I believe that one reason for 'them' getting at me is my failure as a husband and father.
18. I believe that my children are physically retarded.
19. I believe that I have physical abnormalities.
20. I believe that dope has been put into my food to make me irritable.

The method of measuring the paranoid beliefs consisted of a questionnaire, the items of which consisted of statements made by the patient in a series of interviews. Each of the statements was printed on a small 5 in. x 3 in.

index card, and the patient was asked to indicate, on a five-point scale, ranging from 'strongly believe' to 'strongly disbelieve', the strength of his belief of each statement in turn. Arbitrary scores were applied to each of the five choices ranging from 1 to 5. The list of statements is given in Table 1.

The main results are indicated in the graph. The circles on the graph indicate the days on which discussions were held and measures taken. The bottom line of the graph indicates the actual day of the week to which each circle applies. It can be seen that the experiment started on a Wednesday and that discussions

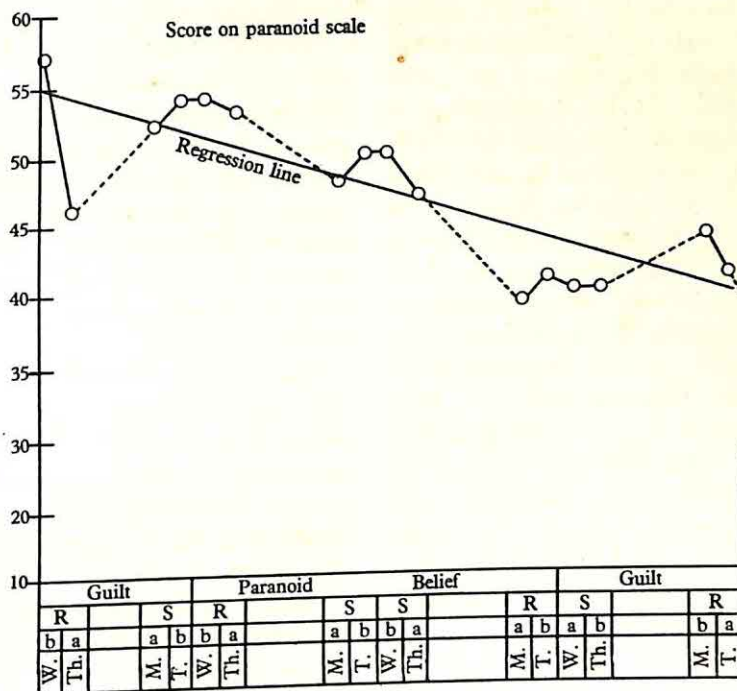


Fig. 3. Changes in paranoid scores. R=Ravenette; S=Shapiro; b=questionnaire before; a=after interview; ---, 4 days between interviews.

The experiment consisted of a series of discussions, eight of which were directed at the rational exposure of the falseness of his paranoid beliefs, and eight were the control discussions of guilt. The discussions were held in balanced order as indicated on the graph. The measurements were made either before or after each discussion in balanced order, in order to obtain a measure of the immediate effects of a discussion. (All these features are indicated in Fig. 3.) Two of the items, Nos. 1 and 10, were found to have changed their meaning for the patient, so the scoring is based on 18 items. The maximum score is therefore 90.

were held four times per week, not being held on Friday, Saturday and Sunday of each week. The content of each discussion is indicated by the words 'Guilt' and 'Paranoid belief'. Explanation of other aspects of the graph are provided on the graph itself.

The main outcomes of the experiment were as follows:

(i) There was a very small immediate reaction to discussions, the difference between scores before and the scores after discussion not reaching an acceptable level of significance.

(ii) There was a highly significant over-all downward slope, as indicated by the regression line in the graph. This means that the patient's

paranoid delusions were getting less intensely held. This observation has no particular relevance for our present purpose, and could be due to a variety of causes.

(iii) It will be seen that the actual curve fluctuates around the regression line. These fluctuations were found to be significant at the 0.01 level. One possible explanation of these fluctuations was that the patient's beliefs became more strongly held over the two week-ends succeeding the discussion of guilt, and less strongly held over the week-ends succeeding the discussion of the paranoid beliefs. This hypothesis was suggested by a statistical analysis, in which it was shown that the curve could be described in terms of the following characteristics: (a) a plateau for each of the five discussion periods, (b) increases of intensity of belief after the second and fourteenth discussions, and (c) decreases of intensity of belief after the sixth and tenth discussions. Clearly, we do not have predictive experimental control here, as we had in the case of the rotation effect, the figural after-effect, and efficiency of recall. The second weakness, of course, lies in the lack of replication. We have no evidence that the findings have general significance.

THE MEASUREMENT OF COMPLEX PSYCHOLOGICAL VARIABLES

One might argue that the kind of examples which have been given so far of the successful use of the single case in research have one characteristic in common. They are all concerned with phenomena which do not pose any intrinsic difficulties of measurement: *degrees* of rotation; *distance* of displacement; *the number* of trials necessary to reach a criterion of efficient learning; and *intensity* of belief in a number of palpably false delusions. In contrast to such simplicity, one might go on to argue, the clinically relevant variables often present considerable complexities. One might take as an example the answers which a patient gives to questions about his mental state. In the first place, much of the content of

his symptomatology may be peculiar to that particular patient. He not only has phobias and miserable feelings, but his phobias and miseries are in certain ways peculiar to himself, being affected by the particular characteristics of his previous history and present experience. Secondly, the way in which he phrases his description of his symptoms will also bear the marks of his individuality.

Three questions arise: (i) Is it possible to measure such clinically relevant and highly specific manifestations? (ii) Is it possible to measure them in such a manner as to make possible quantitative comparisons between changes in different aspects of the same patients? (iii) Is it possible to measure them in such a manner as to make possible comparisons between changes in the illnesses of different subjects?

The writer has, in collaboration with Dr F. Post and Mrs B. Fox (Shapiro, 1961), supported by a grant from the M.R.C., recently begun to try to obtain answers to these questions. At the moment the investigation is being confined to the measurement of unpleasant experiences. A separate questionnaire is constructed for each patient, the items being based on statements made by the patient about his illness. These statements are made in a special standardized interview in which the patient is encouraged to talk about his illness. Additional items have then to be constructed to make possible the measurement of improvement. This is done in accordance with a set of rules, the main aims of which are (i) to preserve the patient's initial formulations, and (ii) to ensure, for all the symptoms, the same underlying scaling system.

In a second interview the patient carries out a scaling experiment in which he is asked to rate each of the questionnaire statements for the degree of unpleasantness of experience it implies. For this purpose he uses a rating scale which has been standardized on normal subjects (Singer & Young, 1941). If the patient produces a rating which is different from that intended by the psychologist it is immediately discussed with the patient, and a new state-

ment, which can be rated by the patient in the required manner, immediately drafted. This ensures that changes in different symptoms, both in the same and in different individuals, can be compared.

The final form of the questionnaire is that of pair comparisons, each of the statements describing a certain degree of intensity of a given unpleasant symptom. Comparisons are made only between different degrees of a certain symptom, and not between symptoms. The method of pair comparisons was chosen for use because it combines the virtues of being both a forced choice method and of requiring a choice between only two statements at a time. It was hoped that, in this way, the influence of irrelevant response sets would be minimized, and the reliability of the measures would be maximized. Pair comparisons also have the advantage of providing a test of the internal consistency of the patient's performance in each testing session.

Each questionnaire takes the psychologist about five hours to construct and requires about two hours' work from a competent typist.

The personal questionnaire has been successfully applied so far to eleven subjects. The lowest verbal I.Q. so far met with has been 83 on the Mill Hill Vocabulary Test. Most of the patients have been fairly severely ill at the time of the construction of the questionnaire, the only failures so far being in the case of a patient who on the whole did not talk at all. The results of this work are now being prepared for publication, and a manual of instructions is in course of preparation.

DISCUSSION AND CONCLUSIONS

There are two main contentions in this paper. The first is that the discovery of a law affecting the psychological function in a single subject will be confirmed by the observation of many other subjects. The second is that com-

plex and clinically relevant psychological variables, peculiar to a given psychiatric patient, cannot be assumed to be beyond measurement, and beyond experimental manipulation. As was pointed out above, the bulk of clinical psychological research is not 'individual centred' but 'group centred'. The observations are in terms of the parameters of groups.

An additional characteristic of a large part of current clinical psychological research is that it is 'indirect' in character, i.e. it tends not to be concerned with investigation of variables which have obvious clinical relevance. In fact one would not be indulging in too much of a caricature if one said that clinical psychologists have become experts on the ways in which psychiatric patients play indoor games and solve puzzles. A more detailed evaluation of the indirect approach has been made elsewhere (Shapiro & Ravenette, 1959).

One might say the clinical psychologist is in his practical work concerned, albeit in an *uncontrolled manner*, with the manipulation of psychological disorder in individual subjects. It follows that fundamental research in clinical psychology should be directed at the *controlled* manipulation of these same phenomena in the same individuals. There appears to be no scientific justification for the present emphasis on indirect, group centred, research, though no one would deny that useful insights and even major discoveries might result. Such an emphasis would only be justified if we had tried, for a number of decades, and on a large scale, to develop direct and individual centred research, and had done so without useful results. No such attempt has been made. It is time that the balance was redressed.

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Personality traits and neurotic symptoms and signs

By G. A. FOULDS*

SOME THEORETICAL DISTINCTIONS BETWEEN PERSONALITY CHARACTERISTICS AND SIGNS AND SYMPTOMS OF NEUROTIC ILLNESS

In his early days in clinical psychology the writer found himself diagnosing hysteria more frequently than his psychiatric colleagues. They would send cases diagnosed as anxiety-states or neurotic depressives, which would be duly returned as hysterics. Not infrequently, after about a fortnight, the psychiatrist would change his diagnosis to hysteria. The possibility presented itself that the attention of the psychiatrist might be fixed on symptoms and of the psychologist on personality traits. The literature provided such unequivocal statements as these: 'True obsessive-compulsive states may develop in personalities with little or no evidence of obsessional characteristics in their previous make-up' (Curran & Guttman, 1949). 'The hysterical personality... is not found in all patients who show hysterical symptoms, but nearly all people of hysterical personality show hysterical symptoms' (Lewis & Mapother, 1941). Obsessoid personalities are described as: 'Extremely cleanly, orderly and conscientious, sticklers for precision; they have inconclusive ways of thinking and acting; they are given to needless repetition. Those who have shown such traits since childhood are often morose, obstinate, irritable people; others are vacillating, uncertain of themselves, and submissive' (Lewis & Mapother, 1941). Hysteroid personalities are described as: '...over-active, unsatisfied with their own capacities and, therefore, pose and pretend; they show lability of affect and exuberance of fancy, egotism, untruthfulness, longing for prestige, sympathy and love; they use illness to

satisfy these needs; they show heightened suggestibility, hypomnesia is common; it occurs more frequently in women who may be both coquettish and frigid' (Lewis & Mapother, 1941). These are, of course, the obsessoid and hysteroid personalities as observed in neurotics. It seems likely that there are innumerable hysteroid personalities, for example, who do not use illness to satisfy their needs, but use rather the stage or writing for women's magazines. A distinction is, however, clearly being made between symptom-sign clusters (or syndromes) on the one hand and personality trait clusters (or types) on the other.

The aims of the present communication are to attempt some further clarification of, and to provide some experimental support for, this distinction.

It has been argued previously that classification is carried out for the convenience of the observer without any necessary implication that fixed entities are being observed (Foulds & Caine, 1958). As Hampshire points out: 'We pick out resemblances in certain respects as the basis of our classifications and neglect other resemblances which, in pursuance of some new need or interest, may be marked later... Reality by itself sets no limit. The limit is set by changing practical needs and by the development of new powers and new forms of social life.' And again, 'Aristotle believed that... correct definitions and classifications of things correspond to some single, eternal scheme of reality'. No critical philosopher believes this now. 'He will rather think of any definition or elucidation of the concept as a reasoned proposal that different types of appraisal should be distinguished from each other in accordance with disputable principles derived from a disputable philosophy of mind. He will admit that this is the domain of

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philosophical opinion, and not of demonstration' (Hampshire, 1959). Within this framework of belief about classification a number of definitions are offered.

A *personality variable* may be viewed as a convenient classification of behavioural qualities along a continuum which can be differentiated from other continua and which provides a distinguishing feature in personality in general. Examples of such continua might be affective expressivity or affective dependency.

Personality variables, as assessed by people with a common frame of reference, are always universal. Thus, with the variable of affective expressivity, certain behaviour is categorized as indicative of affective expressivity and all other behaviour as not indicative of affective expressivity. If the extremes of this variable be 'flamboyant display of emotions' and 'extreme control of emotions', everyone must fall at or between these extremes. The dimension can never be irrelevant to anyone. The variables mentioned by Lewis & Mapother are variables shared in more or less degree by all of us. We are all more or less labile in affect, more or less longing for prestige, sympathy or love, more or less conscientious, more or less obstinate. The extent of the more or less is *the personality trait*. The personality trait denotes a rather consistent position in respect to a personality variable. If all individuals manifested all forms of behaviour from completely uninhibited display to completely inhibited control of emotions in an apparently random way, the variable of affective expressivity would still be identifiable, but the trait would not. Widespread inconsistency and specificity does not, however, seem to be the rule, and the trait concept has been introduced into psychology in an attempt to classify the relative generality, consistency and continuity of responses to somewhat similar situations.

A trait may be *common*, if the position on the particular variable is one that is shared by many other people; or it may be *uncommon*, if it is rarely found in the same degree in others—for example, extreme conscientiousness. A change from even extreme conscientiousness to

over-conscientiousness, in the sense that the individual finds his pre-occupation with rectitude distressful, would be a symptom.

A personality trait may be *prominent* if other traits are rarely found in the same degree in the same person. An individual may, for example, be extremely conscientious, but only moderately quick, only moderately intense in affect. The uniqueness of the person could probably be established on the basis of his position on a single variable had we measures sufficiently sensitive; but there would certainly be little difficulty in doing so with the multiplicity of possible variables which might be chosen. The uniqueness of any person is a resultant in part of different strengths of traits relative to other persons and within himself. The different strengths of traits, both between and within individuals, will have arisen as a result of the interaction between different constitutions and situations which the individuals did little or nothing to seek out and between different constitutions and situations which already differing traits have predisposed the individuals to seek out in order to exercise them.

A *personality type* is an observable constellation of traits which can be distinguished from other such constellations. An example would be the hysteroid personality as described by Lewis & Mapother.

The term trait is being used then as an observable constellation of behavioural characteristics. It does not drive. Reference to any inferred tendency underlying an observed constellation of behavioural characteristics would require some such term as *trait-construct*, which 'might be conceived of as lowered thresholds for certain types of response' (Earl, 1939). Personality traits and types emphasize the continuities in behaviour; whereas symptoms and signs emphasize the discontinuities.

A *symptom* is a change in bodily or mental functioning which the subject reports because it is distressful to him. For example, 'I am afraid to go out alone' or 'I have lost interest in almost everything'.

A *subjective sign* is a change in bodily or mental functioning which the subject reports,

of the significance of which he is not aware, but which to the skilled observer is indicative of such maladaptation as is likely to cause or to have caused danger or distress to others or to himself. For example, 'I know of people who are trying to poison me or make me ill in some way' or 'Sometimes I think of doing away with myself and those I love because the world is such a wicked place'.

An *objective sign* is a change in bodily or mental functioning which the subject does not report, but which to a skilled observer is indicative of such maladaptation as is likely to cause or to have caused danger or distress to others or to himself. For example, clang association or echolalia.

A *syndrome* is a constellation or cluster of symptoms, subjective and objective signs, which tends to occur rather commonly and which is distinguishable from other such clusters of signs and symptoms. Symptoms or signs may occur in more than one syndrome; but the syndromes *per se* must be mutually exclusive.

The distinction between symptoms and signs has gone out of fashion; but it may still prove useful to psychologists. It seems highly probable that symptoms will be utilized more in the diagnosis of neurotics than of psychotics. This would suggest that a greater reliance on questionnaires in neurosis than in psychosis might be justifiable. In relatively well-preserved psychotics, such as many melancholics and paranoid states, subjective signs may be to the fore. Perceptual studies of vigilance and defence might, therefore, be particularly suitable for these groups. In less well-preserved cases, such as many catatonic or hebephrenic schizophrenics or manics, reliance must often be placed on more objective signs. For such cases concentration might profitably be more on expressive movement studies or techniques designed to bring out evidence of thought-disorder.

We are all more or less dependent, more or less quick, more or less retiring and we are so, with possibly some modifications in the more or less, throughout our lives. We do not, however,

all have functional paralyses, fugues, anaesthetics, fits or anorexia nervosa; nor do those who have them have them all their lives. The distinction is not always simple. We do all wash our hands. The obsessional neurotic may wash his hands more often. This is a quantitative distinction only. The normal person, even if he be of obsessoid personality, feels free to decide whether or not he will wash his hands; the obsessional neurotic feels no such freedom and would be distressed by this compulsion itself or by interference with it. This is a qualitative distinction, which may be either a symptom or a subjective sign. A recent factor-analytic study by Sandler & Hazari (1960) isolated two relatively independent factors of obsessional neurosis and obsessional character traits. The distinction they make is very similar to the above. It is a qualitative distinction because personality traits refer, as McClelland (1951) has pointed out to the 'how' of behaviour. How did X do Y? He did it quickly, gracefully, without fuss, independently. We do not seek for recondite motives for his conduct. He did Y4 because he had previously done Y1, Y2 and Y3, and well he is the sort of person who does that sort of thing. Predictions can be made without knowing the cause of behaviour as Peters (1958) has argued. Symptoms, on the other hand, are an indication that the normal consistencies and continuities of behaviour have been interrupted. We seek for an explanation of behaviour which seems strange to us. Harding (1953) has suggested that 'one of the most important of the criteria that guide our verdict of normality' is 'that we believe we can spontaneously comprehend some motivation for the normal person's actions. We may, in fact, be wrong about it, but at least a possible motivation presents itself. We cannot in this way put ourselves in the abnormal person's place and feel that we know why he acted as he did.' If we ask someone why he acted in a particular way or why he holds a particular belief and he is unable to tell us, or he offers an explanation which seems altogether unconvincing, we suspect that an unconscious wish may be operating. Most

people would probably agree that the following reasoning of a patient was unconvincing and invited explanation in terms of unconscious wishes. This patient argued that he was unfit to live, but that he was too cowardly to kill himself. He would, therefore, have to get someone else to do it. The only way to do this would be to kill someone and then he would be hanged. (This was before the new Act. Now he would have to kill one policeman or two non-policemen.) He was, however, a very sensitive man and did not want to kill anyone with dependent relatives who would be left to grieve for his victim. The only person he could think of who had no dependent relative, other than himself, was his mother. If he killed his mother, he would be hanged, and, therefore, there would be no dependent relative left to grieve.

Picture 6 GF of the Thematic Apperception Test shows a man leaning towards a seated woman who is half-turning towards him. Women of predominantly obsessoid personality typically give stories of a husband and wife discussing where to go for their holidays, whether to go to the cinema or not or some such undramatic situation. Women of predominantly hysteroid personality give stories of a husband coming home early and finding his wife writing to her lover or stories of the boss putting an unbusiness-like proposition to his secretary. In the absence of strong evidence to the contrary, a sufficient explanation can be found within Peters's rule-following behaviour model. These particular stories are probably consonant with the normal interests, day-dreams or actual experiences of the obsessoid and hysteroid personalities. When, however, a patient says that both the people in the picture are looking very anxious and that may be the house is on fire, such explanations do not seem sufficient. When the same patient is shown the same picture some time later, she says again that they both seem very anxious. Perhaps there is a flood and they are waiting anxiously for it to subside. Inquiry reveals that she has never been in fire or flood. Her sole complaints were of depersonalization and emotional

flattening. She could never get excited about anything. What made X do Y? What made her give this extremely unusual story? Her husband was so afraid of their having another child that he had for some time been sleeping in the kitchen and their only sexual relations consisted of mutual masturbation. Not infrequently the wife had been left unsatisfied, in a state of considerable excitement. Now she complained of being unable to get excited about anything; but the husband and wife in the stories were waiting anxiously for the flood to subside or for the fire to go out. Thus the breakdown in normal rule-following behaviour could be traced to the intervention of an unconscious wish, or to the defence against that wish.

Symptoms then may be regarded as distress signals sent out by the crew that is heading for danger. They may be relatively easily rescued if they have confidence in the Life Boat crew and co-operate with them. Signs are danger signals sent out by the Lighthouse, which can be interpreted by the Life Boat crew, but not by the crew in distress. Rescue will be the more difficult in that the crew is unaware of its danger and is, therefore, less able to co-operate. In the event of rescue and to avert a recurrence of the traumatic situation, the crew needs to be instructed in the navigational hazards and ways of meeting them.

A number of studies have been carried out to try to determine whether or not this distinction between personality trait-clusters and symptom-sign-clusters has any practical or heuristic value. It was thought desirable initially to limit the number of groups. Two neurotic syndromes were selected—Hysteria and Dysthymia and two personality types—the hysteroid and the obsessoid. The subjects of the studies have, therefore, been divided into four groups: hysterics with hysteroid personalities; hysterics with obsessoid personalities; dysthymics with hysteroid personalities and dysthymics with obsessoid personalities. The dysthymic groups comprised anxiety states, neurotic depressives and obsessionals. The justification for the inclusion of obsessionals is questionable. For practical purposes this was

of little account as they formed only about 5 % of the total.

Diagnostic classification was carried out in the usual way by psychiatrists. Personality classification resulted from psychiatrists' ratings on a hysteroid : obsessoid rating scale, based on the descriptions of these personality types by Lewis & Mapother (1941).

SOME EMPIRICAL DISTINCTIONS BETWEEN PERSONALITY CHARACTERISTICS AND SIGNS AND SYMPTOMS OF NEUROTIC ILLNESS

Given this double classification, it becomes possible to determine whether various psychological test measurements—and, indeed, other clinical data—are related to symptom clusters or to personality trait clusters.

In the first study (Foulds & Caine, 1958) with 68 neurotic women admitted to the hospital, 26 were classified as dysthymics with hysteroid personalities (Dh); 22 as dysthymics with obsessoid personalities (Do); 16 as hysterics with hysteroid personalities (Hh) and only 4 as hysterics with obsessoid personalities (Ho).

Three of the test measures differentiated between hysterics and dysthymics regardless of personality type and five differentiated between hysteroids and obsessoids regardless of diagnostic type.

The first of the three diagnostic measures was the MMPI Depression scale minus the Hypochondriasis Scale. This is a symptom-cum-subjective sign measure. Higher scores were obtained by dysthymics, the medians being: Hh 5; Dh 12; Do 13. These scales probably succeeded where the other MMPI scales failed because the confusion of symptom items and personality items is less marked on the Depression and Hypochondriasis scales than on, for example, the Hysteria and Schizophrenia Scales.

The second of the diagnostic measures was the length of TAT stories, hysterics giving the longer stories (Medians: Hh 101; Dh 78; Do 84). The third successful measure was the Maze 'distraction' effect. Both these measures are estimates of objective signs. The total time

taken to do years 6-14 of the Porteus Mazes is recorded. Subjects do the test again in exactly the same way as before, except that they count 1, 2, 3, etc., after the tester. The time taken on this second performance over the time on first performance multiplied by 100 gives what has been called 'the distraction effect'. The medians were: Hh 77, Dh 66, Do 68. Practice effect, as measured by two non-distraction performances, gives a median of 75, so that counting has, in fact made little difference to the hysterics, but has speeded up the dysthymics.

Of the five personality measures, two were speed measures. Patients rated as obsessoid took longer on their first Maze tracing time (Hh 250, Dh 274, Do 368 sec.) and on Progressive Matrices (Hh 33, Dh 36, Do 56 min.). On the Maze test, the obsessoids lifted their pencils during tracing, contrary to instructions, more often than did hysteroids (Hh 8, Dh 7, Do 16). On an Extrapunitive Scale derived from the MMPI, obsessoids scored significantly lower (Hh 9, Dh 9, Do 6).

On the fifth personality measure, hysteroids score higher on the Superiority Index (Foulds, 1958) (Hh 3, Dh 1, Do - 1). Here the subject is presented with twenty-four situations in which a person has made a provocative remark to which four possible answers are supplied. Two of these blame the provoker, i.e. are extra-punitive; and two the provoked, i.e. are intro-punitive. For each situation the subject has first to select the answer she thinks she would make, then the answer she thinks ought to be made and, finally, the answer she thinks most people would make. The absolute difference between what I would say and what ought to be said is a measure of self-criticism; between what most people would say and what ought to be said a measure of criticism of others; the algebraic difference between the self-criticism and criticism of others give the final measure of Superiority (if criticism of others be higher than self-criticism) or of Inferiority (if self-criticism be higher than criticism of others).

A similar study was carried out with sixty-two neurotic men (Foulds & Caine, 1959). Once again some test measures differentiated

between personality types regardless of diagnosis; whilst others—or rather with men one measure only—differentiated between diagnostic groups regardless of personality type. The measures were not, however, the same for men and women. Psychiatrists experienced greater difficulty in diagnosing men—as evidenced by more frequent changes of diagnosis and more unusual class names to describe the conditions. This greater apparent homogeneity has been supported by the test results.

The third study (Foulds, 1959) was a successful replication of the first, in that 77 % of cases were correctly identified as against 78 % in the original study. In the fourth study reported in the same paper, it was predicted that: (i) diagnostic measures would change more than personality measures, even after 1 month; (ii) the diagnostic measures of dysthymics would change more than those of hysterics in such a way that (a) hysterics and dysthymics would cease to be distinguishable on re-test; whereas (b) hysteroid and obsessoid personalities would be distinguishable both on test and re-test. All the predictions were correct. The difference between the change in diagnostic scores and the change in personality scores was significant at the 1 % level of confidence. The difference between hysterics and dysthymics on first testing was significant at the 1 % level of confidence; on re-test the difference was nowhere near significant, p being much greater than 0.2. Hysteroid differed from obsessoid personalities on first testing at the 1 % level of confidence and on re-testing at the 5 % level of confidence. There was, therefore, a tendency for the difference to diminish, but it was not obscured.

Table 1 shows the medians for the combined groups of women from the first and third studies. Despite the very small number of Ho's their medians are in the predicted direction in six of the eight measures. Table 2 shows the z (Mann-Whitney U test) and p values derived from the four groups and eight measures.

The MMPI: 'D-Hs' measure is efficient in distinguishing between hysterics and dysthymics. The small Ho group has been over-zealous in scoring significantly lower than the Hh group.

The Maze 'distraction' measure is efficient in distinguishing between Hh on the one hand and Dh and Do on the other. The Ho results do not support this measure as unequivocally a diagnostic one.

The TAT measure of 'words per picture' is rather unsatisfactory.

The 'personality' measures are much more satisfactory. Maze and Progressive Matrices time measures are extremely efficient. Maze 'lifted pencils', though difficult to interpret, is almost equally so.

The two 'attitude' measures are somewhat less successful but are nevertheless useful.

A retrospective study (Foulds & Caine, 1959) of the case histories of the patients used in the investigations mentioned showed that some of the data were related to diagnosis and some to personality type. Thus within the depressive subgroup—virtually the only one to receive ECT—this treatment was confined almost exclusively to those rated as having an obsessoid rather than a hysteroid personality. This applied to both men and women.

Table 1. Median scores of neurotic women on 'diagnostic' and 'personality' measures

No.	Group	'Diagnostic' measures			'Personality' measures				
		TAT words per picture	Maze 'distraction'	MMPI D-Hs	Maze time	Maze lifted pencils	Matrices time	Extra- punitive	Superior- ity
23	Hh	97	77	6	264	8	35	9	2
7	Ho	98	61	-6	378	12	66	5	3
33	Dh	80	66	13	293	8	34	9	1
28	Do	91	68	14	368	14	60	6	0

Table 2. *z* and *p* values for the inter-group comparisons on 'diagnostic' and 'personality' measures

	Hh:Ho		Hh:Dh		Hh:Do		Ho:Dh		Ho:Do		Dh:Do	
	<i>z</i>	<i>p</i>	<i>z</i>	<i>p</i>	<i>z</i>	<i>p</i>	<i>z</i>	<i>p</i>	<i>z</i>	<i>p</i>	<i>z</i>	<i>p</i>
'Diagnostic' tests												
MMPI: D-Hs	2.45	0.014*	2.41	0.016	2.34	0.019	3.54	0.000	3.24	0.001	0.63	0.529
Maze												
'distraction'	2.16	0.031*	2.27	0.023	2.23	0.026	0.55	0.582*	0.33	0.741*	0.10	0.920
TAT words												
per picture	0.49	0.624	2.54	0.011	1.38	0.168*	1.03	0.303*	0.43	0.667*	1.22	0.222
'Personality' tests												
Maze time	2.62	0.009	0.65	0.516	2.14	0.032	2.62	0.009	0.78	0.435	2.29	0.022
Matrices time	2.08	0.038	0.70	0.484	2.80	0.005	0.45	0.653	2.19	0.029	3.60	0.000
Maze lifted pencils	1.81	0.070	0.23	0.818	2.72	0.007	2.21	0.027	0.17	0.865	2.64	0.008
Superiority index	0.32	0.749*	0.66	0.509	3.05	0.002	0.44	0.660*	1.05	0.294	1.86	0.063
Extra-punitiveness	2.11	0.035	0.52	0.603	2.01	0.044	1.80	0.072	1.11	0.267	1.60	0.110*

* Result contrary to hypothesis.

As predicted, some improvement had been noted in the case history within the first week with significantly greater frequency among hysteroid than among obsessoid personalities regardless of diagnosis, although dysthymics were more frequently judged to have recovered or improved on discharge.

SUMMARY

Within any agreed frame of reference personality variables must be regarded as universal. A personality trait is taken to be a relatively consistent and enduring position in respect to a personality variable. Symptoms and signs of mental illness are distinguishable from traits in that they are neither universal nor necessarily enduring. Indeed, they indicate a break in the normal continuity of behaviour.

Studies have been reviewed in which certain test measurements have differentiated groups classified on the basis of symptom-sign clusters; whilst other test measurements have differentiated groups classified on the basis of personality trait clusters. It was further down

that the symptom-sign measures changed in a predictable way after an interval of 1 month; whereas personality trait measures remained relatively stable.

It was implied that psychiatrists may sometimes, in arriving at a diagnosis, change their universe of discourse from symptom/sign clusters to personality trait clusters and conversely. The patient initially diagnosed as having an anxiety state (who has a hysteroid personality) is often found to settle down within a few days of entering hospital. This may be because entering hospital is part of her at least pre-conscious campaign for, say, bringing her husband to heel; whereas entering hospital may be viewed by the person of obsessoid personality as an admission of failure. The psychiatrist in the first case may become more aware of the histrionicity, the lability and shallowness of affect than of the now quiescent palpitations, tremors and free-floating anxiety. He shifts his attention from symptoms and signs to personality traits and, in our view, mistakenly feels tempted to change his diagnosis to hysteria.

The type of formulation suggested may reduce this tendency and thus increase the reliability of the classification of neurotic patients.

Perhaps the outstanding question that pre-

sents itself, as a result of these studies, is why, of three people rated as having a similar type of personality, does one develop hysteria, another an anxiety state and the third nothing at all?

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Can a blow cause cancer?*

By W. S. INMAN

CAN a blow cause cancer?

Many victims believe that it has done so. In our present ignorance of the cause of cancer, can we afford to dismiss the persistent idea without due investigation?

Whilst waiting for the pathologist or biochemist to settle the question, ought not the clinician to share in the inquiry? Every doctor in the land could contribute. Meanwhile, may a psychoanalyst add his mite from a single instance?

For a long time he has concerned himself with the significance of accidents, and the term 'accident-prone' carries with it a suggestion of wishful thinking. He wants to know a good deal of the circumstances of the blow. Was it self-inflicted, or caused by someone else? If the latter, what was the relationship between them? Was it due to carelessness, or was it seemingly unavoidable? Had it ever happened before without ill consequences? And so on. That the cancer may have been present *before* the injury only complicates the inquiry; why hurt the breast at that particular time in that particular way?

But simple question and answer without some consideration of unconscious processes neglects a powerful—some people think the most powerful—factor in the causation of illness. That is where the psychoanalyst comes in; as in dreams he must look for hidden significances of events, and see how far interpretation fits in with actual facts. If he can deduce the probable occurrence of the latter from a recognition of the hidden significance, so much the more convincing seems the evidence.

By the courtesy of an ophthalmic colleague I recently had the opportunity on three occasions to interview in this way a patient suffering from malignancy.

Miss B, a maternity nurse, aged 46, twisted her heel on 17 February 1958, fell downstairs, and landed on the newel at the bottom. On the top of the post was a sharp metal point in the form of a lion which bruised her right breast. Fearful from the first, she watched closely the site of the injury

and three or four weeks after the accident found a small lump at the exact spot. If present before, it could not be felt by trained fingers.

Whilst on a private midwifery case—where the function of breasts cannot be ignored—she realized in May that the growth was almost certainly malignant; she sought medical advice and on 23 July the breast was removed.

In March 1960 she noticed a tiny swelling the size of a pin's head on her right shoulder. On 6 May—just two years after the dreadful realization of her state—she had 'a heavy midwifery case' and the next day 'felt rotten'; the left upper eyelid drooped, a squint without diplopia developed, and she became very thirsty. Third nerve paralysis and diabetes insipidus were diagnosed.

The left fundus showed a large solid detachment of the retina which was taken to be the result of a choroidal metastasis. Other metastases were found in the skin—there were five growths in the scalp alone—spine, ileum, left ovary, left adrenal, the other breast, and in the neighbourhood of the hypothalamus. This desperate situation was met five weeks later by excision of her ovaries and adrenals.

I first saw her some weeks later still, on 15 August. Beyond the fact that she was wearing glasses with the left eye occluded because of diplopia which had eventually developed, there was nothing about her to suggest invalidism. Buxom, frank in manner, and ready to face facts however unpleasant, she looked what she actually was, a thoroughly competent, self-possessed, well-extraverted nurse; a valuable asset to any community.

Since Miss B could offer no reasonable explanation of the fall, which was out of conscious character, I sought unconscious motivations. Suppose it had been a dream of falling, and not an actual event; what might have been its interpretation? In figurative language falling can mean several things: mankind can fall from grace; everyone knows the meaning of a 'fallen' woman; married women 'fall' when they conceive; and in a way a child falls from the womb when it is born. Thus the word carries a wide sexual significance.

* Manuscript received 15 May 1961.

Which applied to Miss B? I chose the last, and asked if 17 February was her birthday. I was wrong, but only by three days. She was born on 14 February. In a dream the lion would have a symbolic significance; why not in an unexplained fall? Here I would interpolate an experience of nearly forty years ago. A critical general practitioner friend visited my out-patient clinic and bluntly asked: 'What is this nonsense about dreams?' I offered to demonstrate with the next patient who came in. It was a woman in her late thirties. Did she ever dream? Yes, she had a recurring nightmare, of being chased by the devil, but he never quite caught her, because he was lame. She was leaving the room when my friend said scoffingly, 'Well, you haven't learnt anything from that'; whereupon I called back the woman and asked: 'How did your father break his leg?' She replied: 'In an accident in the dockyard many years ago.'

Applying now a similar reasoning, and with the lion's (not a lioness's) head and mane in mind, I asked if her father had had a good head of hair and worn a beard or a moustache. The guess was correct; his body had not been particularly hairy, but there was no doubt about his head, and he had had a moustache.

Miss B 'never dreamed' and I could not therefore get information about symbolic use of animals in her sleeping state. Then what took the place of the lion in her waking life? Probably dogs (usually male in popular parlance); of these she had been afraid from her early childhood, whilst to cats (nearly always referred to as 'she') she had been indifferently tolerant. Perhaps dogs sensed hostility based upon fear, for she recalled having been bitten on the hand by a Sealyham which she was holding for a friend; only a few years ago she had been attacked by an Alsatian, and, more recently still, frightened by a Great Dane.

Only at a subsequent interview had I the wit to ask if she had ever seen a lion, even at the Zoo? She had; and the occasion had been connected with thoughts both of birth and death. In December 1956 she had been attending Mrs X in childbirth. Mrs X lived close to the winter quarters of a celebrated circus. The roaring of the lions could often be heard. Curious to see them, Miss B went along and was invited by the proprietor to look round the show. The incident was especially memorable because Mrs X had lost her first baby, whilst the second was premature but under Miss

B's care had survived; and then Miss B had had to leave the case and return home because her own mother had had a stroke. When Miss B was 18 months old, her mother had also lost a baby; it was stillborn.

With such associations the lion on the newel now seemed more than a metal ornament. Beautiful in shape, it still represented a dangerous animal, and typified ambivalence. It must symbolize a malevolent, yet physically attractive influence in her life. Who was this evil genius? Without doubt the father. Was he living? No, he had died, 'about Easter five or six years ago'. From what? And then Miss B *calmly* told me that he had cut his throat. No wonder that even the self-contained daughter was vague about the actual date. Detachment about such a horror is often acquired only at the price of forgetfulness.

He had been a bad father and a bad husband—moral, but given to excessive drinking and gambling. Miss B was the second child of a family of three, the others being a brother four years older and a brother roughly two and a half years younger. They had always been afraid of their father and scattered when he came home. He was 'utterly selfish'; he had 'a cruel streak', and Miss B had known him to go three months without speaking to any of the family. As an adolescent she learned to overcome her fear, and 'stood up to him' (alas! for the fall downstairs!) to protect her mother, to whom he was sometimes 'murderous'.

Two memories were poignant, the one of jumping on his back in fun, and of his responding by painfully pinching her legs and thighs; the other, of playing cards when she was about ten years old. She suddenly had cramp in her hands, dropped the cards, was struck in the face by her father and got a black right eye. A correspondence may now be seen between these events, the fall on the lion, and the cancerous blinding of the left eye.

To what extent did this fearful home atmosphere influence Miss B's emotional and physical development? Since the present illness concerned primarily the breast, and the breast is designed for the feeding of infants, and Miss B was unmarried and yet devoting her whole life to the bringing forth and feeding of other women's children, I was curious about her own potential maternal capacity, the first obvious signs having of course developed at puberty. Her periods had begun at the age of twelve, with a rhythm of 23 days, and from the first they had been painful for seven or

eight years. A bad start! Moreover, her breasts were very small until she was over 30; and they were painful 'at ovulation' about ten days before the period. It seemed clear that whatever had caused the bad start was still exerting its baneful influence during the development to full womanhood. Once established, her physical health was excellent; for 26 years before I first saw her she had not had a single day's illness of any sort. What of her emotional development? She had never had any conscious desire to be married, and that, in so vital a maternity nurse, inevitably suggests an unconscious emotional repression with corresponding endocrine adaptation.

When did the repression begin? What was her earliest memory? It was the birth of her younger brother, when she was 2½: having arrived from the waters of birth he was being bathed in a blue bath.

Two and a half is an impressionable age, and a birth then, as I shall show, can leave an indelible mark upon the minds of little children. The memory of a terrifying father in the home at the same time would also be duly registered. She had no conscious recollection of any emotional upset at the time, though I think deep analysis would reveal sufficient traces of it to be convincing. To illustrate the continuing effect upon conduct of the advent of another baby, I will interpolate the short story of a woman in her middle seventies who complained to me of recent double vision. Examination suggested to me a stirring up of an old squint rather than a fresh paralysis. Squint in childhood is commonly related to a birth in the family. Drawing a bow at a venture I asked: 'How has your sister, two or three years younger than you, been disturbing you lately?' She replied: 'She has just come to live with me, and been very annoying.' Seventy years had not wiped out the hostility aroused by the infant's intrusion, but the patient knew nothing consciously of its present influence.

How can this be applied to Miss B? She herself had been breast-fed, but, she thought, less successfully than had been her elder brother. Marital unhappiness is not conducive either to joyous child-bearing or to efficient nursing, and in fact the next child was stillborn. Of the feeding of the boy born two years and seven months after Miss B I could get no history, but I think it fair to assume that all did not go smoothly during the breast phase, and base the assumption upon later events. She remembered taking his part when he was about

the age of *fourteen* and being 'frustrated' by his father. Indeed he found life so intolerable that when 15 he went to Australia and stayed there four years. However, he came back, married, and when his first child was being successfully breast-fed, his own mother interfered and insisted upon the substitution of a bottle. Was history repeating itself?

Miss B delivered his second child, and it should be remembered that she herself was a second child. To use her own words 'I dug my heels in' and, warning off her mother, insisted that there should be no interference this time with the breast-feeding. In this instance the hostility was towards her mother, not the newborn child.

The baby was born on 18 February, and it was on the day before the *fourteenth* anniversary that her heels landed her upon the lion and brought her face to face with death. Could she not keep up longer the struggle with the father when the next generation came to puberty? She confessed that she was extremely proud of the brilliant boy, whom she had brought into the world, and who represented the brother who had crashed into her early unhappy childhood. Indeed the boy was now her chief interest in life. Again, was history repeating itself?

Let me now return to her relationship with her lion-father. Like her young brother she too left home at an early age, and, without telling her father of her intention went to be trained as a nurse; and in this vocation she was so successful that at the age of 27 she was a fully fledged matron of an emergency wartime maternity hospital. When this was closed in 1946 she became head of a local Memorial Maternity Hospital where, striving for perfection ('asepsis was so good that not one of my patients ever had a *breast* abscess'), she overworked until in 1951 change of management gave her an excuse to return to private maternity practice.

On leaving the hospital in September 1951 she expected that the Committee would tell her father, who was living with her mother nearby, how much she was missed. Perhaps she hoped to shame him into decency, for she was still anxious about his attitude towards her mother.

Was his conscience pricked? He left no word; his actions must speak for him. On the Wednesday before Easter, six months later, he took his own life. He was 73.

There were three special factors about his death

which excited my curiosity: the time, the method and the place. Why had he chosen to die at Easter? Many years ago (in May 1941) I wrote: 'Illnesses beginning at Christmas, like those beginning—or becoming worse—at Easter are always exciting events to speculate upon. Some day the Church and the medical profession will awake to a realization of the immense amount of clinical material furnished by these two Church festivals, the one dealing with Virgin Birth and the other with equally amazing phenomena, death and resurrection.'

Was this another instance of morbid seasonal influence? Of her father's religious life Miss B knew nothing. Indeed she knew very little of his early life, for 'he lied prodigiously about it'. He never attended church, but his children had been brought up to do so; his sons, however, alone were confirmed.

One of the causes of suicide is an unbearable sense of guilt, and Mr B certainly had much on his conscience. He had been a bad man. What has the church, which orders Good Friday as the proper time for vicarious sacrifice, to say about the Wednesday before Easter? I looked in the Book of Common Prayer and in the epistle for the day read 'Where a testament is, there must also of necessity be the death of the testator: for a testament is of force after men are dead; otherwise it is of no strength at all whilst the testator liveth. Whereupon, neither the first testament was dedicated without blood: . . . Moses . . . took the blood of calves and of goats . . . and sprinkled both the book, and all the people saying, This is the blood of the testament, which God hath enjoined unto you. . . . And almost all things are by the law purged with blood; and without shedding of blood is no remission.'

Thus runs the ancient law. The long Gospel for the same day brings the matter dramatically nearer home. 'And being in an agony, he prayed more earnestly; and his sweat was as it were great drops of blood falling down to the ground.'

Both documents are worthy of consideration in relation to sacrifice for the forgiveness of sin. But like other erring patients of whom I have written (Inman, 1948), Mr B could not delegate the duty to another, whether beast or god. At the appropriate time he must carry it out in his own person. In these days he could have chosen many other ways of destroying himself. No other would serve. Blood there must be, and blood there was in

plenty. And as if to add credibility to the interpretation I am offering, he went forth to kill himself 'about midday', the exact hour on Good Friday when the Church begins to celebrate the death of Jesus. He was buried on Easter Saturday.

Was the place of the fatal act also significant? He took his wedged-open razor into some bushes by the seashore to complete the pattern of his life appropriately. Psychopathologists may see there-in something symbolic, as suggestive as the nursery tale that life begins under a gooseberry bush.

If now I claim that a religious festival had a profound influence in determining the time and manner of Mr B's death—and it could only have done so through some early childish experience, not traceable because all his life he was extremely reticent about his past—was it possible that there was a comparable significance in the date when his daughter fell upon his symbolic effigy? That year, 17 February was the day before Shrove Tuesday, the day which ushers in Lent, the preparation for Easter and the anniversary of her father's death. If indeed it had significance, this must have been acquired in childhood, for Miss B is not now a regular church-goer.

But the father had died in 1952, and she did not injure her breast until 1958. If we suppose a buried tendency towards morbidity, how can the time-lag be accounted for? Did some other powerful stimulus provoke activity?

Intuition may well be defined as forgotten experience. In Miss B it was highly developed; pain had seared her mind early; and she had a knack of sensing the emotional atmosphere as soon as she entered a house. In February 1958 she went to attend in a distant town a woman in childbirth and at once sensed an unsatisfactory marriage. She was right; the patient was very unhappy and a marital separation had been abandoned only for the sake of the children. The woman was having her fourth child; counting the stillbirth, there had been four children in Miss B's family. The patient's husband, much older than his wife (a father substitute) was 'a beast' (the lion). He was 'a horrible man'; she 'couldn't stand him' (the fall); and at breakfast he would 'get his knife into his son', a boy of 7 (Miss B's young brother); and most significantly of all, the wife originally came from Miss B's native town. 'Her home was only 50 yards from here'; the girl's father had wisely opposed her marriage; she had waited until he died and then had married 'the brute' (the lion!).

It needs little imagination to see the effect of such a massive stimulus on a delicately balanced nature. Such a situation was like thrusting a flaming torch into a barrel of gunpowder and Miss B's complexes exploded accordingly, with disastrous consequences to her metabolism.

It gives me intense pleasure to record that when I saw her on 4 March 1961 she looked the picture of health, with a complexion that a girl of 17 might envy. Recent X-ray examination 'from top to toe' showed that all the metastases had disappeared. The left vision was nearly as good as the right, though there was still a tendency towards diplopia when she looked upwards and inwards.

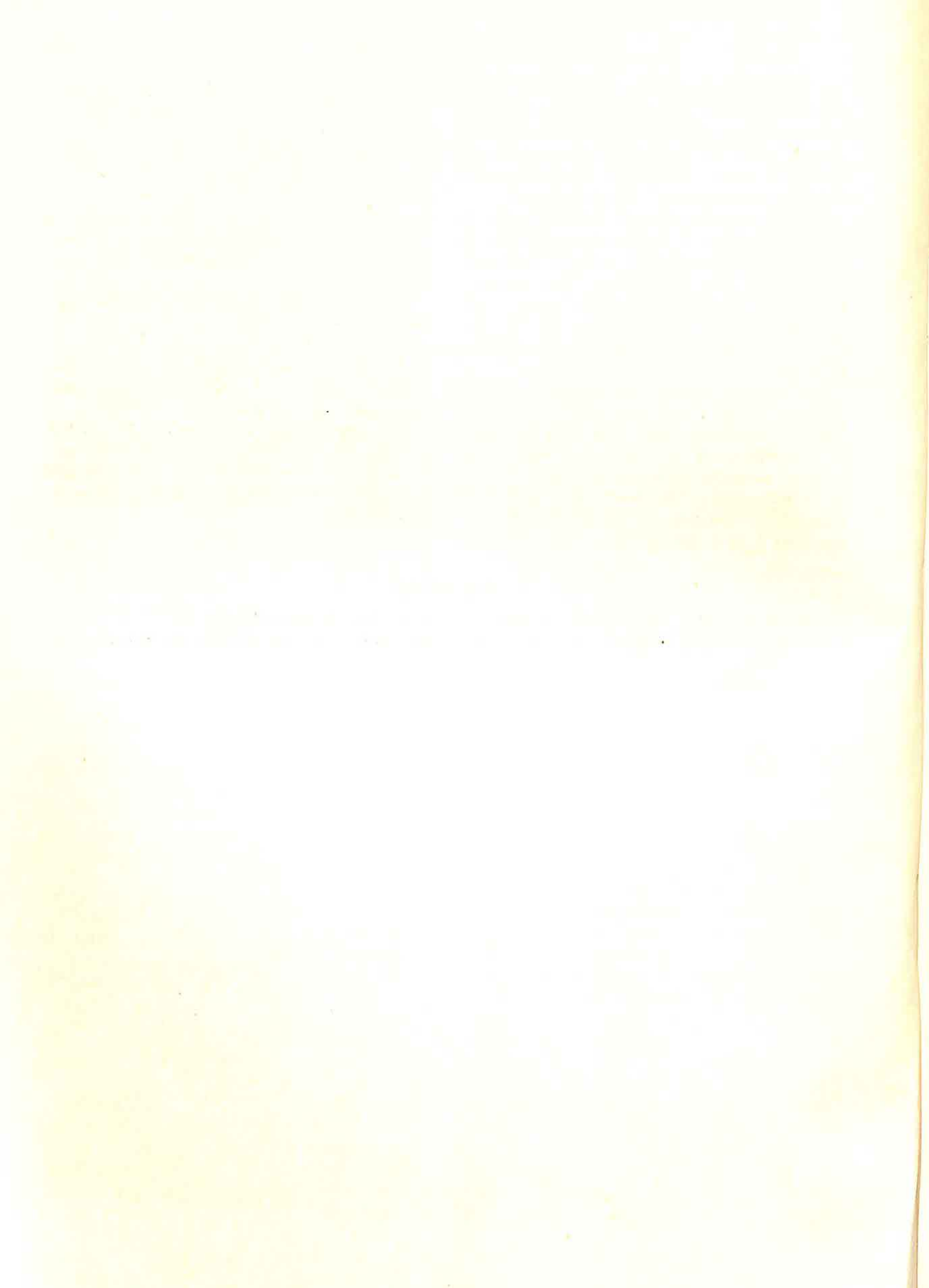
There seems no doubt that surgically induced endocrine changes have been the direct cause of Miss B's remarkable escape from death by cancer. Is it unreasonable to think that emotionally induced endocrine influence may have been a factor in the origin of the cancer? Inevitably there must arise the question of a still-persisting frustration. As I have already said, Miss B 'never

dreamed'. Notwithstanding, after a long interview on 3 February 1961 I told her that my probing into the mysteries of the unconscious would probably make her do so that night. To her surprise—and she thought, my amusement—it happened. It simply consisted of hearing herself say: 'We will be married on Tuesday, 14 February, as it is St Valentine's Day, and my birthday.' A strange dream by a middle-aged woman without adrenals or ovaries!

Straight from the unconscious comes the wish-fulfilment apparently little disguised as to time, but carefully concealing the identity of the bridegroom. And it seems to throw back to the days of childhood when St Valentine's Day had more emotional significance than it has today. Moreover, it tends to support my thesis that the date of the accident, so soon after this anniversary now linked up with thoughts of birth, marriage and death, was a contributing factor in the subsequent morbid events.

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A note on the bisexual significance of the testes

By BERNARD BRESSLER*

Discussing the very young boy's discovery of himself through a libidinal preoccupation with his genitals and the disappointed search for a corresponding penis in all animate nature, Freud (1923) adds the following footnote: 'It is remarkable, by the way, what a small degree of interest the other part of the male genitals, the little sack with its contents, arouses in the child. From all one hears in analysis, one could not guess that the male genitals consist of anything more than the penis.'

Clinical observation by most analysts has confirmed this statement. If the testes are valued at all we find they are given an importance by that type of woman who in seeking to deny and mitigate the absence of a penis in herself will evolve a breast-testicle fantasy. Greenacre (1950) has shown the dynamic reason for this in her discussion of what she has called the Medea complex. 'Some children (girls) often clearly eliminate or disregard the penis and fixate rather on the testicles, while the breast is exalted over any male genitals. In these patients the image of the breasts seems especially strong back of that of the penis, the fantasy being: "I will have better and bigger ones when I grow up."'

Rare is the male patient who expresses any feeling towards his testicles—or even refers to them when confronted with his castration anxiety. I can report two notable exceptions. The first was a patient who, unable to relinquish his feminine identification as a child would, during adolescence, gaze at his nude body in the mirror, concealing his penis so that only his testicles showed. Clearly, this male patient equated the testes with the breast.

A second patient contributed what might be considered thematic variations on the childhood enigma of sexual identification. For him the testes were surrounded by fantasies belonging to all significant phases of childhood perception and development—but, needless to say, in a negative sense. Diagnostically, this 22-year-old white male was a borderline case with a rather typical problem,

the search for identity. Prior to treatment his personal confusion was so intense that, at times, he was unable to distinguish between right and left. This created havoc in his everyday life; for example, he could not drive a car.

In analysis, while he was still at the stage when he sought to wrest all satisfactions from the breast, he produced the most unusual constellation of elaborate beating fantasies. These were associated with his masturbatory activity. In essence, the fantasies revolved around persons with very thin arms being overpowered by aggressors with muscular arms. The defeat was accomplished with a peculiar kind of interlocking (or surrounding) squeezing of the thin arms. Other variations on the humiliation theme of the thin-armed individuals consisted of the patient being starved, etc.

This patient retained many vivid stories from childhood of how his mother's milk turned 'blue' when she fed him and finally, that there was no milk for him at all. After each period of masturbation, therefore, he would go on a diet of protein to 'fill himself up again'. In other words, he would acquire a 'solid breast' *within himself* in an attempt to placate his sexual guilt and to deny the fact that his mother's breast had been skimpy. It became clear that for this patient, the 'thin arms' served as an intermediate link between the penis-breast fantasy and was involved, as expected, with his confused sexual identity.

At one point, two years after the patient had entered analysis, when he had tackled some of his problems associated with moral masochism and was therefore able to shift from this area of sexual fixation and attain quite an improved degree of self-identification, he went home on a visit. For the first time in his life he was able to express his aggressions towards his family and had come out rather well. The success of the encounter raised his spirits considerably and he returned from this short vacation 'feeling... like a whole person'.

In the analytic hour to be reported the patient immediately plunged into a discussion of a movie he had seen concerning *Cyrano de Bergerac* and spoke at great length on *Cyrano's* sensitivity about

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his nose. 'I nearly totally identified with him. Like me he was cursed with something long and thin... a weakness which prevented him from having women.'

For this patient, too, the nose was a symbolic penis but, as his associations showed, these objects could both be linked to his penis-arm equation. The connexion reminded the patient of one of the few heterosexual affairs he had had and evoked the feeling that his penis was 'not productive'. When he mentioned the word 'productive', he passed flatus loosely as a regressive anal way of showing that he had power and was free to express it. Significantly, this man had suffered from asthma since childhood. Power was related to his anal phallic fantasies which centred on respiratory activity.

Thus, it would seem that as the infant draws air into his lungs, experiencing the free sensation of passage, the slightly older child finds that flatus is somehow libidinally invested. In another paper dealing with respiratory incorporation during the phallic phase, Greenacre (1951) observes: 'The child said "Look at that". He said it to his father with intense curiosity, pointing to his own little penis in a state of partial erection. He watched the trees, the clouds, the flowers as they bent in the breeze. "Are they alive?" he would ask. "What makes them move?"'

Later, Greenacre associates this movement with flatus: 'When he passed flatus, it was not at all easy for him to tell whether he had begun to pass a bowel movement or whether this was only air... The phallic phase... is a period of autogenous genital stimulation... characterized by a sense of genital life... an expansion of vitality without corresponding material, corporeal or visible change.'

It would seem, however, that a corporeal change does take place. The alternating erections and loss of erections with or without urination, with or without an ejaculation, result in a visible corporeal change which the child experiences.

To return to Greenacre's main observation. If movement equals life which may or may not be produced by a bowel movement or the passage of air, there was a definite reason for this patient to speak of his penis as 'alive' and to generate fantasies which would also 'kill it'—a fantasy being as air itself. For if the free sensation of movement is acceptable to the child, it would naturally become prohibitive for the adult re-

living that period of self-awareness since the patient, retreating from his oedipal conflicts (while trying to resolve them) is no longer a child. In the intervening years he had adopted a solution which was revealed by an omission. Continuing his parallel identification with Cyrano, the patient did not refer to Cyrano's respect for his sword. With this omission the sword was ignored as a symbol and, at the same time, denied as an inferior penis. But later, perhaps subliminally recalling a facet of his masturbatory fantasies and seeing the thin arms that held him to feed him and deny him—the unproductive breast which he had likened to his unproductive penis, the patient associated the penis-arm equation to the sword. But unlike his romantic counterpart, the patient dealt with his present-day aggressions in the following manner: 'I am witty, but very biting, and make many salacious remarks to women. Afterwards, they are either insulted and leave, or else are interested. If they are interested I next try to prove that I am misleading them and that really I have no penis. I become silly, effete, super-civilized instead of blasphemously witty. Therefore, if possible, it can be said I show myself to have a quasi-penis and I must prove to women that the quasi-penis is the only one I have.'

Once he had identified his penis as a false creation and saw its vitality as finally turned inward against him, becoming a cutting instrument to weaken him and sever him from women, he was able to remove some of the distortions surrounding it and, as he had done in previous hours, attempt to make it 'real'. He next said: 'You know I don't think of the penis and balls as being in the same place. I have a fantasy that they are unrelated.' When asked what he meant, he replied: 'Well, I've always had the impression that the balls are behind and that they are low class. At home, we call them dingle-berries.'

Fortunately, I had to question him directly, since the expression was unknown to me. The question released what would seem to be a completed circle of fantasies and associations. The word dingle-berry belonged to home (mother and father), or rather had itself returned in the patient's unconscious to that area of fantasy where mother and father were the introjected power lodged in his genitals, whom he kept apart—his and not his. 'Dingle-berries', the patient informed me, 'refer to little balls of faeces on the end of the hairs near the arse hole and the testicles.'

In the same way that he had, in fantasy, separated his penis from his testes, he now saw women as basically different from men. For, if his testes were of a lower class, his penis was '... definitely higher class. The balls are grubby... a squatting woman who's covered with hair all over. It reminds me of bushes; you know, women are earth-bound.'

When I remarked that he had associated women with stool, he agreed, adding that if women were like 'shit', they were round and substantial nevertheless. Previously, he had depreciated women because at best they had only an anal penis. Now, the act of squatting in the bushes, '... reminds me of a woman's role; it is not very imaginative... their main interest is in security. A woman is an end in herself because she spends so much time on herself. Like the testicles, women are there, passively, and men are the active ones.'

With the fantasy partially revealed, the patient began to consider himself as more masculine, as he had in previous hours. But now, he talked about his penis in words that were at first reminiscent of Cyrano's eulogies on his nose. 'It (my penis) is acceptable to me as a symbol of dynamism, imagination, spontaneity, liberalism. A mouth-like organ full of something to say and to be indulged; it is all things my parents praised me for, my intelligence, etc.'

Having found the albeit fantasied value of his penis, the patient followed a seemingly biological but certainly adolescent impulse to separate himself from the breast-like objects, his testes, and continue on the road to male identity—again, by devaluing his testicles; later he was to liken 'balls-shit' to his mother who was 'full of a sense of proportion' and he strongly associated the 'two balls' attached to the male genital with 'two breasts'. Parenthetically, it can be noted that since the little boy senses little pleasure from his testes, some children can liken them to the 'unfeeling breast'. Certainly, at the moment, the testicles represented: 'stodginess, the strength of women, my mother, common sense, keeping my room clean, conservatism.'

It was as though the fantasied division of his genitals represented the split in his still nascent ego. After comparing his testes to the painfully slow way in which he digested other people's imaginative works, the patient then described how these attitudes (i.e. penis versus testicles) represented parental figures. His description, naturally,

reflected his self-image; it can be said that this fantasy attained full resonance in that it finally rested in the parental images. Significantly too, with the following associations, the patient returned to the equation of the penis-arm but this time quite differently. 'The penis-arm is a representation not of my father exactly, but what I thought and was told my father was: intelligent, generous, witty, above conflict, respected, indirectly powerful, but mixed with this is a feeling of weakness.'

Thus it would seem that the thin arms which held him from anything but masturbatory activity were also of a paternal nature and had clearly been introjected into the patient's need to identify himself with his father: 'Mother always said "Isn't he mean", jokingly, but also mockingly. He never took a directly masculine part in the family life. This image was the image that I inherited from my father. My mother seemed to see the same qualities in me as she reported in my father.'

Once more, in trying to dissociate his penis from his testicles, he referred to his mother and this time began to explore that area of childhood where the fantasy acquires a reality. He saw testicles as 'unobtrusive' like women. '... Women should stand behind men and not the other way around. You talk of getting arse even though the arse isn't the object of intercourse. Of course, women are identified with food or future faeces. Mother instructs the child in the use of his arse, not his penis, which she tries not to mention, but the faeces, like the penis, are represented as being repulsive, as the child will need the faeces I suppose. A child or adolescent may feel guilty about his penis but not his testicles, which are simply about half related to the penis and half to the faeces. Perhaps the child tries to lose his penis through letting out faeces, for since the faeces is a sort of detachable testicle then perhaps the penis, too, can be eliminated. I am just beginning to realize that the penis is stronger than the soft testicles and that the penis protects the testicles.'

Finally, he added associations which centred on his feelings that the penis was 'free so that it can rise above the balls, although the balls, perhaps, are stronger because they are more solid and, at times, more dependable'. Although the freedom of the penis included its capacity for erection and ejaculation, he considered this, in itself, to be dangerous since 'the penis is no longer solid: it has lost something'.

Of possible significance here, however, is the fact that an event in his real life, a fairly successful encounter with his family, had given him enough strength to face the introjected parents of childhood and, thereby, grow towards manhood.

SUMMARY

The patient made a clear association not only between testes and breasts but also testes = anality = femininity and, essentially, equated testes with the anal penis which, to him, was something

to be depreciated. It is notable too that he greatly stressed the passivity of the testes, contrasting this with the activity of the penis in terms of its erectability as well as its ability to ejaculate.

Anatomically and embryologically the testes stem from the same tissue as the ovaries and there is a corresponding relation between the scrotum and labia majora. It is significant to note that the Yiddish word for testicles, 'bayzem', is translated as 'eggs'. In German testes are also called eggs, and in Arabic 'beydat', which means 'eggs', can also be translated as testes.

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Anxiety and emotional impoverishment in men under stress*

By EVA BENE

Most psychological investigations dealing with emotionally disturbed people have tended to show that there are constitutional or early developmental reasons for their disturbances. The aim of this paper is to discuss some aspects of the emotional lives of a number of men who were exposed after childhood to considerable environmental stress. A large proportion of these men appear to have suffered consequently from emotional difficulties, and it seems possible that their lack of adjustment was related to the fact that they lived for many years under environmental conditions which made satisfactory adaptation impossible.

THE METHODS EMPLOYED

The author had the opportunity of studying projective test material obtained from sixty-one adult male Hungarian refugees, most of whom were professional men, students, or workers. The tests included the Rorschach Test, the Sentence Completion Test devised by Sacks & Levy (1950) and an adaptation of the 'Projective Questionnaire' described by the O.S.S. Assessment Staff (1948). The sentence completion test and the projective questionnaire were given to the refugees in Hungarian and their responses were translated back into English.

The Rorschach responses were scored according to certain formal Rorschach categories, also according to indications from the content of the responses. Unfortunately the scoring of the records for colour and shading had to be omitted. Since the author had not herself administered the test, her scoring for colour and shading might not have been sufficiently reliable. The responses to the other tests were scored according to principles described elsewhere (Bene, 1957).

The present study is based mainly on the Rorschach responses of the refugees. Since an indi-

* The opportunity to undertake the research reported here was given to the author by a United States University which has asked not to be mentioned by name in connexion with this study. Manuscript received 31 March 1960.

vidual is free to see a great variety of things in inkblots, his responses to the Rorschach can be regarded as samples of his emotional and phantasy life, and it seems permissible to draw some conclusions from these samples as to his emotional and phantasy life in general. One cannot draw the same conclusions from tests which are more highly structured. The sentence completion test, for instance, contained four items which had to do with anxiety, so that every one of the refugees had to mention these feelings in his responses to this test, but one cannot tell how many would have expressed anxiety in a spontaneous manner. On the other hand, the results of the sentence completion test show the sort of things the refugees claimed to feel anxious about.

The emotional difficulties of the refugees were investigated from three points of view: aggression, anxiety and emotional impoverishment.

THE ENVIRONMENTAL STRESSES SUFFERED BY THE REFUGEES

To give some idea of the environmental stresses suffered by the refugees, some of their responses to the sentence completion test and the projective questionnaire will be quoted.

Responses describing disruption of interpersonal relations

'I feel that my father seldom had a chance to learn to know me. He was in a Russian prison camp for ten years and only came home in 1955. Now I have lost him without any hope of seeing him again. I wish I could lose the fear of being separated from my parents for ever. Compared with most families mine suffered a lot. My father was in Siberia, my aunts were deported. My grandmother had an apartment which the Communists wanted, so they took her away in the middle of the night, together with two of her grandchildren. She had to live in a chicken-house infested with rats. What feelings are the most disturbing to you? To be here without my family. I did make an attempt to escape with them but it

was unsuccessful. I had to leave them behind. *What situations are you most afraid of?* To appear ungrateful. This happened often in the past ten years, because to protect my mother from unpleasant political things I could not always be truthful with her.'

'*I could be perfectly happy* if I did not have to live in a foreign country, but could live in my own country with my family.'

'*I know it is silly but I am afraid* of being deserted by my wife. During the eleven years I was imprisoned I became less good company than I used to be.'

'*The people I like best*—I left them at home.'

'*I could be perfectly happy* if my fiancée were here.'

'*Compared with most families mine*—I do not have a family. All but one were killed by the Nazis and the only one left was killed by the Russians.'

Responses expressing feelings of anxiety and guilt concerning people left in Hungary

'*The worst thing I ever did* was to leave Hungary without my family, although I had to, otherwise I would have been shot. I did not know it would take so long to see them again. *My secret ambition in life*—there is none, there is no secret, I want to have my four little children with me.'

'*My fear sometimes forces me*—it does not force me to anything. I am afraid that something bad might happen to my parents.'

'*If my father would only be allowed* to do easier work. He used to be the head of a division of the Department of Internal Affairs and now he has to work as a labourer.'

'*I would do anything to forget the time*—I cannot forget the past. I left my country and came here. I came to live in freedom while my country was subdued by a foreign nation. I cannot forget it. It is just as it was when the Turks killed four-fifths of the Hungarian people. *What experiences make you feel like sinking through the floor?* That is exactly how I felt when I was crossing the border, when I was getting out, while other men were still fighting behind me.'

Communism

'*I don't like people who are our enemies*, who are Communists. They won't let us live. If you have two pieces of cloth they take one away. I wish to buy and eat what I want and not what they want. *What experiences would be most disgusting?* The

Communist system. They treat people like animals. God created the world and man.'

'*My fear sometimes forces me*—forced me, in Hungary, to walk quickly when I heard steps behind me.'

'*My greatest mistake was*—I had many. I trusted a friend who denounced some of my other friends.'

'*My greatest mistake was* to join the Communist party. My greatest weakness is that I am too credulous. *To me the future looks*—it looked nice and shiny but it turned out that not everything is gold that shines. Now the future looks desperate. *I look forward to*—I do not know what I could look forward to.'

'*My greatest mistake was* to believe for a while that Communism can save us from Fascism.'

Prison experiences

'*I would do anything to forget the time* I fell into the hands of the Russians and was tortured and forced to tell about my companions. *What experiences would be most disgusting?* Those people in prison who did not wait for their turn but pushed themselves ahead, and the German prisoners who became spies for the Russians. *What kind of people do you find most difficult to be with?* People who betray others for a meal. Life is materialistic, especially in prison.'

'*What experiences would be most disgusting?* Those in Russia. Eating bread made from nettles and being beaten by the Russians and escaping.'

'*The worst thing I ever did*—I stole a piece of bread from a fellow prisoner. It made me sick for days, although he had done the same to me. Sometimes a piece of bread made the difference between life and death.'

'*My most vivid childhood memory is* when I escaped from a Russian prison—I was about seventeen years old—in Budapest in 1944. I was walking with a group of twenty prisoners and we were guarded by only one soldier. I was the last and at a turning I went in the opposite direction. Half the prisoners in that prison in Godollo died.'

Responses showing persistent fear of Communism

'*I know it is silly but I am afraid* of these questions. In 1955 I was talking about politics with a soldier in a tailor's shop and he was imprisoned for it.'

'What feelings are the most disturbing to you? The fear of being forced to go back to Hungary and to be deported to Russia. How often do you have them? In my dreams and before I fall asleep.'

'I know it is silly but I am afraid that the Communists will imprison me again.'

'What things are you most afraid of? Of being innocently accused, of being taken away by the Secret Police.'

The revolution

'What things give you a feeling of awe, of overwhelming greatness? The attitude of the Hungarians during the revolution. A fifteen-year-old boy throwing gasoline on a Russian tank, knowing that he would die.'

'I would do anything to forget the time I walked in the destroyed streets of Budapest in 1956, looking for signs of life.'

Two young students said

'When I was younger I felt guilty about having killed Russians, maybe five of them. I did confess it to a priest in Austria.'

'I would do anything to forget the time when I was lying between two dead bodies. The worst thing I ever did—I shot four people dead. What I want most out of life is to live peacefully, no war, no killing. What situations are you most afraid of? Of fighting in small, dark places.'

On being a refugee

'I wish I could lose the fear of the English language. It is like Chinese to me. I thought that my knowledge of German would help, but it doesn't.'

'What feelings are the most disturbing to you? That nobody belongs to me. Loneliness.'

'What makes you feel inferior? People do, who make me feel that I am a foreigner, who treat me as if I was inferior.'

'What feelings are the most disturbing to you? Arriving in the U.S.A. without any money, no money to buy cigarettes, no money to go to the lavatory.'

Fear of the future

'I wish I could lose the fear of the future, of the foreign environment.'

'I wish I could lose the fear of the future. It is difficult to start a new life, to start from the bottom in one suit of clothing.'

'I know it is silly but I am afraid of the future. I was a lawyer at home and I won't be able to work as a lawyer here.'

'I know it is silly but I am afraid of the American way of life, of their different mode of thinking.'

Homesickness

'What feelings are the most disturbing to you? Nostalgia for Hungary. Lack of close friends.'

'What moods or feelings are the most disturbing to you? Homesickness. How often do you have them? Homesickness almost always.'

'I wish I could lose the fear of not being able to return to Hungary even for a visit.'

'My fear sometimes forces me—I hardly dare to say what I think. Sometimes I feel I would rather be back home in Hungary.'

The experiences of the refugees were also reflected in their dreams as shown by responses given to the following item:

'Everyone has bad dreams or nightmares at some time or other, such as after over-eating. What would be the worst dream to have?'

'Recently in a dream I saw myself at home, locked in a cage, with no hope of escaping. Or dreaming that something bad is happening to my family and I cannot raise my arm to help.'

'Dreaming that I am going back to Hungary to help some people and the Russians deport me.'

'Escaping and being caught. I dream it in the Russian language.'

'I keep on dreaming that I am in the revolution, fighting the Russians.'

'I dreamt that I was a prisoner in a building and then I escaped into a forest and they were after me on bicycles.'

As can be seen from these responses the refugees had experienced considerable environmental stress. During the war and since, many people in Hungary were killed, deported, imprisoned, or were denied the material necessities of life. No one was immune to these dangers. When the refugees made their escape into a safer world they had to pay for this safety with the disruption of their interpersonal relationships and the separation from everything familiar: people, countryside, culture and language.

The present sample of refugees were tested between December 1956 and September 1957. Most of them were living in a camp outside New York, and were tested at the time when, without knowledge of English, money, status or friends, they were attempting to start their new lives in the unknown vastness of America. A few were tested in England shortly after their arrival there.

ANXIETY AND EMOTIONAL IMPOVERISHMENT AS
FOUND IN THE TEST RESPONSES OF THE
REFUGEES

*Rorschach responses indicating aggression
and anxiety*

From the responses the refugees made to the Rorschach cards, those which involved seeing aggressive behaviour, or objects and events with aggressive connotations, such as weapons, explosions, teeth, etc., were taken to indicate aggressive feelings. Responses which involved someone or something associated with danger, destruction or unpleasantness were taken to indicate anxiety, as were responses concerned with blood, ice, snow, clouds or fire. Table 1 shows the frequency with which responses expressing aggression and anxiety

Table 1. *Frequencies with which responses expressing aggression and anxiety were given by the refugees to the Rorschach cards*

No. of responses	Percentages of refugees giving various numbers of	
	Responses expressing aggression	Responses expressing anxiety
0	56	16
1	21	18
2	14	21
3	3	11
4+	6	34
	100	100

Table 2. *Various types of Rorschach responses expressing aggression and anxiety and the percentages of refugees who gave such responses*

	Percentage of refugees
Aggression	
Verbal aggression	25
Weapons, explosions, teeth seen	21
Physical aggression	16
Anxiety	
Someone or something frightening or threatening	56
Someone or something damaged, diseased, falling, killed	52
Blood, ice, snow, clouds, fire	30
Someone or something repulsive, ugly	15

occurred in the records. Table 2 shows the kind of aggressive and anxious responses given by the refugees.

As can be seen from Table 1, less than half of the refugees gave responses expressing aggression and only 9% gave three or more aggressive responses, whereas most of the refugees gave responses expressing anxiety, and 45% gave three or more such responses. Table 2 shows that more than half of the refugees saw both something threatening and something suffering destruction in the Rorschach cards.

*Responses expressing anxiety given to the
sentence completion test and the
projective questionnaire*

What the refugees reported of their anxieties in the sentence completion test and the projective questionnaire indicates the sort of things they felt disturbed about, and so supplements their Rorschach responses. The responses given to these tests are summarized in Table 3.

Table 3. *Responses expressing anxiety given to the sentence completion test and the projective questionnaire, as well as the percentages of refugees who gave such responses*

	Percentage of refugees
Responses to do with separation anxiety, loneliness	
Longing for parents, for family	83
Longing for sexual love	37
Longing for Hungary	32
Responses to do with Russians, Communists	
Anxieties to do with Russians, Communists	69
Anxiety dreams about Russians, Communists	38
Worry about safety of parents, family, left in Hungary	22
Responses to do with present situation	
Anxieties about the future	46
Anxieties about being a refugee	36
Others	
Unrealistic fears	34
Anxiety dreams not included above	29
Anxieties to do with war	25

Table 3 shows that the vast majority of the refugees were affected by the disruption of their interpersonal relationships. In many cases their feelings of longing for their parents and families were mixed with feelings of guilt for having left them in Hungary. A number worried that their parents might be punished for what they, their sons, had done. In addition the majority of the refugees were still under the influence of their own frightening experiences with the Russians and the Communists. This is shown particularly well by their dreams and unrealistic fears. Their responses concerning anxiety dreams were made to an item which asked what would be the most frightening dream they could imagine. Many did not have to invent any such dreams, since they actually had anxiety dreams. Some dreamt that they had returned to Hungary to help someone, had fallen into the hands of Russians or of the Secret Police and were unable to escape again. Others dreamt of being imprisoned and threatened with torture. In response to an item which asked about fears, some told of fears of nightmares, of dying, of explosions, even of fear of stepping on a mine.

In addition to their anxieties concerning the past, their responses also told of anxieties to do with the future and indicated that the refugees worried whether they would be able to learn to speak English, to find suitable work, to continue their studies, to find ways and means by which they could eventually lead worthwhile lives.

We have previously seen that the Rorschach responses of the refugees suggested that many had excessive feelings of anxiety. Now we saw that their responses to the other tests indicated that their environmental circumstances caused them much worry and fear. In addition to the fact that they lived for many years in a police state, these worries and fears were due to the disruption of their interpersonal relationships and to their status of being refugees in an alien world.

Rorschach responses indicating emotional impoverishment

Investigations such as that of Niremberski (1946), of internees at Belsen Camp, show that people tend to become apathetic if they live under extreme environmental stress. The refugees were not comparable with the sample of Niremberski because the stresses under which most of them had lived were not as extreme. Not even those refugees

who had been in Nazi concentration camps or in Russian labour camps were comparable with the people examined in Belsen, because some considerable time had elapsed between their release and the time they were tested. This does not exclude the possibility that some people in Hungary had become apathetic under the influence of their experiences. What seemed unlikely was that any of the refugees were apathetic, because had they been so, they would probably not have had sufficient energy and enterprise to make the flight across the border. However, it seemed possible that the stresses under which some of the refugees had lived were severe enough to cause emotional impoverishment, and an attempt was made to investigate this possibility.

It was assumed that emotional impoverishment is accompanied by a barren and stereotyped phantasy life. Further, it was assumed that this can be recognized in Rorschach records. It was assumed that this would be indicated by a tendency to see parts of people instead of whole people, by percepts which are vague or so poorly defined that they could be seen almost anywhere in the inkblots, by many animal responses, by a small number of responses, or by the absence of responses to some of the cards.

On this basis an emotional impoverishment scale was constructed. Table 4 shows the scoring categories for this scale and the scores the refugees received on these individual categories. Table 5 gives the distribution of the total emotional impoverishment scores of the refugees. This table points out that 61 % of the refugees showed at least one of the signs of emotional impoverishment, while 21 % received emotional impoverishment scores of 3 or more.

In order to examine whether a barren and impoverished phantasy life really implies emotional impoverishment, refugees with various emotional impoverishment scores were compared from the point of view of the frequency with which they had given responses indicating inner resources, interest in people and instinctual drives. It was thought that if the emotional impoverishment scale measures what it is supposed to measure then there should be an inverse relationship between the scores the refugees obtained on this scale, and the frequencies of their M, H, and FM responses. The results of these comparisons are given in Table 6. It can be seen that the data in this table show the expected inverse relationship.

Table 4. *The scoring categories for emotional impoverishment*

	Percentage of refugees
Score 0	
0-9% human detail responses	90
0-9% unstructured, undefined responses	79
Less than 50% animal responses	74
More than 15 responses	85
No rejection of cards	82
Score 1	
10-14% human detail responses	7
10-14% unstructured, undefined responses	10
50-59% animal responses	16
13-15 responses	10
Score 2	
15-19% human detail responses	2
15-19% unstructured, undefined responses	7
60-69% animal responses	7
10-12 responses	5
Rejection of one card	13
Score 3	
20% or more human detail responses	2
20% or more unstructured, undefined responses	5
70% or more animal responses	3
Rejection of two cards	5

No subject rejected more than two cards, or gave less than 10 responses.

The relationship between the emotional impoverishment scores of the refugees and the number of their responses expressing anxiety and aggression

Emotional impoverishment means, among other things, that the individual has difficulty in accepting his feelings of anxiety and aggression. Consequently one can expect an inverse relationship between the emotional impoverishment scores and the number of anxious and aggressive responses given by the refugees. As can be seen from Table 7, this expectation was confirmed.

It should be added that 46% of the refugees also gave responses which seemed to have involved

pleasant associations. Such pleasant responses can even be found in some of the records showing emotional impoverishment or much anxiety. This seems to show that the emotional impoverishment or excessive anxiety of the refugees did not necessarily destroy their ability to react in a positive manner.

Table 5. *Distribution of emotional impoverishment scores*

Score	Percentage of refugees
0	39
1	25
2	15
3	3
4+	18
	100

Table 6. *Comparisons between refugees of various emotional impoverishment scores (E.I. scores), in respect of the frequencies of their M, H and FM responses*

	E.I. score 0	E.I. score 1-2	E.I. score 3+
	N = 24	N = 24	N = 13
Mean no. of resp. = 30	Mean no. of resp. = 29	Mean no. of resp. = 18	
% of M responses	11	9	6
% of H responses	13	11	7
Ratio of FM to A responses	1/3	1/4	1/7

Table 7. *Relationship between emotional impoverishment scores and number of responses expressing anxiety and aggression (N = 61)*

	Number of responses expressing aggression and anxiety			
		0-2	3 +	Total
Emotional impoverishment scores	0-1	13	26	39
	2 +	15	7	22
	Total	28	33	61

$\chi^2 = 6.85$ (significant at the 0.01 level).

THE HISTORY AND RORSCHACH RECORD OF
A REFUGEE

The life history and Rorschach record of one of the refugees is given below. This particular refugee was chosen for two reasons. First, his Rorschach record is probably the most morbid of all. Secondly, the morbidity of his phantasy life could be explained both by genetic and early developmental factors, and also by the environmental stresses he suffered in later life.

The father of this refugee was a poor labourer. His mother died, presumably of insanity, when he was one year old, and his father married again. He was rejected, neglected and much punished by his step-mother. He had, however, a warm relationship with an aunt who lived nearby, and he spent most of his childhood in her house. He went to school until the age of 16, and became a worker of some skill. He married, was very devoted to his wife, and had a good relationship with his parents-in-law. He was happy, comfortably off, and felt that life was worth while.

In 1945, after the occupation of Budapest by the Russians, when the town was half destroyed, the informant and his family hid in a cellar without food or water. After a while it became imperative that he go in search of water for his young child, and was picked up by a Russian soldier. He escaped, but while trying to make his way back to his family he was captured again and taken to a camp which was without shelter, food or water, and which already held some 30,000 men. He was kept in this camp for several days. Eventually he was taken to a camp in Russia, where he had to work in mines, under great deprivation. The food consisted of soup made of cabbage and grass. He spent many years there and saw most of his fellow slaves die. He was forced to help take off the clothes of the dead so that they could be redistributed, and had to help to bury the corpses. The graves were barely covered and during the summer there were bones and a stench all over the camp. He developed oedema, lost almost all his teeth, and weighed only 40 kilograms.

Eventually he was released and returned to Budapest. He rejoined his family, and after six months of tender loving care was well enough to start work again. However, he now realized that Budapest had changed. People were discouraged and frightened. They lived from day to day not knowing what would happen to them, and

not daring to say or do anything for fear of persecution. He too, as a former prisoner, lived in increasing fear of the Secret Police.

At the outbreak of the revolution in October 1956 he engaged in an encounter with a member of the Secret Police. The mob became incensed and trampled the Secret Police man to death. He then acquired a rifle and went around shooting as many Russians as he could. When the Russian tanks returned on November 5 he was cut off from his family, and when he tried to rejoin them he was captured and taken to a camp. He discovered a way of escape and encouraged others to follow him, but just before they reached the border some of his companions were killed by mines and others were captured by Russian soldiers.

Before examples of his Rorschach responses are given it must be mentioned that his wife had been raped by Russian soldiers, and that many women who were raped contracted syphilis or gonorrhea. Because of the circumstances of his escape his wife and family remained in Hungary and he was greatly worried about their fate. He could hardly bear the thought that he was separated from them again, probably for ever.

Examples of his Rorschach responses:

To card V. 'This looks bad. It is the vagina. It has been infected by somebody. This is no good. It has been torn apart. It is inflamed. It is much more widely open than is normal. The womb is here; it might be infected, or it could be a tumour or cancer. It must be painful at intercourse.'

To card VI. 'This is also the damaged vagina. The canal is in order but inside she has gonorrhea. The black parts are the germs.'

To card VII. 'She is bleeding. These two stripes show her illness. What else? It looks like clouds—but it is not clouds. You can see the drops of blood. She is bleeding all the time.'

To card VIII. 'She is bleeding, the flesh is inflamed, it looks like a pink rose covered with blood. These look like animals—two animals, bears, who suck her blood. Her sick flesh is thrown into the street and they are devouring it.'

To card X. 'Black blood. Green, yellow, pink colour. The different coloured spots mean that she is very sick. They are signs of cancer. My sister died of cancer of the breast.'

Schafer (1954) says: 'When qualitatively extreme themes prevail, it is strongly suggested that the patient's consciousness is flooded with normally unconscious threatening thoughts, fantasies,

feelings and impulses, and that a psychotic breakdown or primitivisation of defense and adaptation has occurred. Then the Rorschach record is likely to be overflowing with gore, devastation, filth, decay, lust, sexual perversity, devouring, mutilation or horrible deformity, or any combination of these.'

In a footnote he adds: 'Up to a point, patients who have been in psychoanalytic therapy and who, as a result, may be characterized by non-pathological openness of consciousness to normally unconscious content, are exceptions to this rule; so are some psychoanalytically-oriented psychiatrists and psychoanalysts.'

A long succession of threatening experiences might have a similar effect on consciousness as has confrontation in psychoanalysis with threatening phantasies. The beloved wife of this refugee was raped by a Russian and now the Russian bear was devouring his motherland. He himself had spent eight years among devastation, filth and gore, had seen people killed and had killed others himself. While the Rorschach responses of this man could be signs of mental pathology—his mother had been insane and he had an unfortunate childhood—they could also be non-pathological reflexions of the experiences he had during the last ten years. Actually, the question whether his Rorschach responses do or do not indicate mental illness is answered by the medical report of this man which says: '... it is important to note that he has never had any significant changes in mood, thought or behaviour. Indeed this is a healthy individual who has functioned well all his life.'

DISCUSSION

The present investigation dealt with test responses of sixty-one Hungarian refugees who had lived for a long time under considerable environmental stress, whose Rorschach records resembled those of neurotics, and in some cases even of psychotics. While this group of men, like any other, probably included certain individuals who had personality difficulties, it is unlikely that it consisted mainly of neurotics or psychotics. According to their medical histories the behaviour of these men had been, on the whole, rational and resourceful during years of frustration and had remained so, despite traumatic experiences such as loss of status, loss of fortune, loss of family members, persecution, prison, torture, etc. Some

of these men had spent years in Russian slave camps where they withstood conditions which had caused the death of many others

The refugees were tested shortly after they arrived in America. The question which has been asked is how the environmental stresses to which they were exposed affected their emotional lives.

The results of this study indicate that the refugees tended to have frightening phantasies of persecution and destruction, and that they did not lose their fears by escaping from their threatening environment. Their inner defences against persecution were inappropriate in their new surroundings. It seems that one cannot change one's picture of the external world and the mechanisms for dealing with it, immediately on moving to a new environment, but only after it has enabled one to acquire new and different experiences.

The test results of the refugees also show that people who escape from a threatening environment develop strong guilt feelings if others, to whom they feel close, have remained there. Many of the refugees felt guilty for having left Hungary without their parents or other members of their families, and worried about their fate. This was particularly so if they had left someone behind for whom they felt responsible, or who was in danger of being victimized.

The strangeness of the new environment also tended to give these men objective fears and inner tensions. These fears had to do with the fact that they did not know whether they would be able to make a living, to continue their professional work, their education, to find suitable accommodation, and so on. Their inner tensions arose from the disruption of their interpersonal relationships, their rootlessness and loneliness, and from the fact that they found themselves in a state of almost infantile helplessness. They could not speak the language, were unfamiliar with the customs, did not know their way about, and had neither status nor money. It seems that the sudden transplantation of individuals into alien surroundings tends to evoke in them the kind of anxieties which ordinarily accompany regression.

Those Rorschach records of the refugees which did not show marked anxiety indicated emotional impoverishment. This suggests that environmentally induced anxieties, like neurotic anxieties, may become too difficult to bear so that a state of repression and ego-restriction sets in. A similar finding was reported by Thaler & Schein (1956)

who worked with American soldiers who had been prisoners during the Korean war. These authors state that at the time of their liberation most prisoners showed 'paucity of emotion' and 'withdrawal reactions'. While a few days after their liberation the behaviour of these men was hardly distinguishable from that of other troops, their test results continued to show anxiety, guilt, and 'constriction of responsivity'.

These findings of Thaler & Schein support the results of the present investigation. If people are exposed to considerable environmental stress, then they appear to resemble neurotics in their emotional and phantasy lives even if they do not resemble them in their behaviour. The reason for this might be that if lack of adaptation is due to environmental factors, and if no grave neurotic conflicts become activated by the stress, then the ability of the individual to act rationally and realistically does not become impaired. However, inability to adapt, for whatever reason, will produce anxiety.

We may ask why the test responses of the refugees expressed only relatively little aggression

against the environment. Frustration may be assumed to generate aggression, and these men had been frustrated for years. The answer might possibly be that due to the breakdown of their interpersonal relationships, their feelings of guilt and helplessness, they were feeling depressed rather than angry. Aggression was turned against the self rather than against the environment.

How harmful the effects of excessive environmental stress can be was shown by the much discussed traumatic neuroses of the two world wars. That such stress in its various forms seriously affects the emotional lives of people even when it does not result in an obvious deterioration of their behaviour may be assessed from the results of the present study.

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The Coloured Progressive Matrices as a measure of intellectual subnormality

By J. E. ORME*

THE PRESENT STUDY

Intellectual deficiency, quite rightly, is not now considered the sole criterion of mental subnormality. It remains, however, an important aspect of assessment in this area. Nevertheless, many limitations remain in the intellectual assessment of the mentally subnormal. The more obvious faults of the Binet and Terman-Merrill scales have been largely avoided by the Wechsler Scales (Clarke, 1958). But the Wechsler Adult Intelligence Scale (W.A.I.S.) standardization for subnormal levels leaves much to be desired. Another problem is the heterogeneity of its subtests—which tends to be complicated rather than simplified by the use of verbal and performance scales (Maxwell, 1960). There are some advantages to sinking many shafts into intellectual functions but one does not know precisely where these shafts have been sunk.

The Coloured Matrices has proved effective in work with normal and disturbed children (Raven, 1956), and with normal and disturbed elderly people (Orme, 1957). Martin & Wiechers (1954) obtained the high correlation of +0.91 between it and the Wechsler Intelligence Scale for Children (W.I.S.C.) with 100 children. The test would appear to be potentially useful in mental subnormality, and the present study investigates this possibility.

Coloured Matrices performances of 203 patients, aged 16–65, with W.A.I.S. full-scale I.Q.'s between 40–80 were obtained. The following Wechsler subtests were given: Information, Comprehension, Arithmetic, Digit Span, Picture Completion, Picture Arrangement, Block Design, Object Assembly. The patients, who were in no way specially selected, were from mental subnormality hospitals in the Sheffield area.

As there are marked trends with age on the

Table 1

Age	N	P.M.		W.A.I.S.		Correlation W.A.I.S./P.M.
		Mean	S.D.	Mean I.Q.	S.D.	
16–25	48	16.66	8.78	61.81	10.41	+0.98
26–35	40	16.93	6.59	59.10	11.46	+0.86
36–45	49	12.75	5.46	55.75	9.61	+0.74
46–55	41	13.17	5.20	60.80	5.83	+0.97
56–65	25	9.72	2.25	58.44	5.77	+0.72

Combined correlation of W.A.I.S./P.M. for whole sample ($N=203$) using Z score derivation is +0.93.

The Coloured Progressive Matrices, Sets A, Ab, B, is a version of the standard Progressive Matrices, designed to give a better spectrum at the bottom end of the scoring range (Raven, 1956). Over many years the standard Matrices test has proved to be one of the most homogenous measures of what is variously called 'g' factor, fluid ability, non-verbal performance—and possibly Hebb's intelligence 'A'.

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Matrices test, the sample was split into five age-groups and the results calculated separately.

RESULTS

Mean scores, standard deviations and inter-correlations for each age group are presented in Table 1.

It can be seen the overall agreement is very high. The combined correlation of +0.93 indicates the Matrices test has over 86% of the variance in common with the Wechsler full-scale I.Q.

There appears to be a decreasing correlation with increasing age. This probably reflects the average decrease of non-verbal performance with age and the lessening of its importance in the W.A.I.S. I.Q. An exception to this trend is the 46-55 age-group where the increased coefficient is probably due to this group being relatively brighter than the other age-groups, giving a better score distribution from the point of correlation coefficient calculation. A further point concerns the slight increase in Matrices score from the 16-25 age-group to the 26-35 group, although the Wechsler I.Q. decreases. This increase is in any event contrary to the usual decrease (in the normally intelligent) of non-verbal performance from 25 years onwards. This might be a chance variation, but could link up with clinical suggestions of the 'late maturation' that is said to occur in psychopathic and/or intellectually subnormal subjects in the twenties and thirties.

With 'normal' subjects the W.A.I.S. standard deviation is 15—and just under 6 for the Coloured Matrices. From these figures and the data in Table 1, a table of roughly equivalent Coloured Matrices and W.A.I.S. I.Q. scores can be calculated for each age-range (see Table 2).

Table 2. *Coloured Matrices Score equivalents at different ages for W.A.I.S. I.Q.'s*

I.Q.	Age				
	16-25	26-35	36-45	46-55	56-65
80	24	25	23	21	18
70	20	21	19	17	14
60	16	17	15	13	10
50	12	13	11	9	6
40	8	9	7	5	2

SUMMARY AND CONCLUSIONS

Coloured Progressive Matrices scores and W.A.I.S. full-scale I.Q.'s were obtained from 203 mentally subnormal subjects, aged 16-65, within the 40-80 I.Q. range. Correlation between the two measures indicates the Coloured Matrices is an efficient measure of intellectual subnormality. It also has the advantages of being (a) a quickly administered test relatively uninfluenced by attainments or manipulative ability, (b) a test of homogeneous composition. As such, it would appear to have potentialities in work with the mentally subnormal.

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Reviews

The Roots of Crime. By EDWARD GLOVER.
(Pp. 422. 45s.) London: Imago. 1960.

There can be little doubt or argument that the study of crime and criminal behaviour and its origin in the persons who exhibit it belong to all realms of human study; to the psychological, the social, the legal and even to the history of cultures. Primarily it is the legal concept attaching to certain forms of conduct which call for the attention and the punitive response of a community which feels itself offended by the act. It is to be separated from the Tort which relates man to man in a legal sense although here too the community has laid down rules for the regulation of injuries as well as contracts. Throughout the world the relation between civil and criminal offences has been made clear by shifting the boundaries. This in itself suggests a progression in the concept of injury and its punishment, for at one time and in various communities even murder was punished by the community and by the family of the victim. There is clearly something very basic to human nature in the attitude to crimes in that the distinction between the civil and the criminal offence transcends frontiers. Drama, Tragedy, and in our own age Comedy has dealt with the issue of Crime from Treason to Parricide (which latter may be not wholly unconnected with the soci-political form of Treason).

The claim of Psychology and particularly Psychiatry to disclose the roots and characteristics of crime is of recent origin, and perhaps psychoanalysis in its attempts to expose the heart of the human situation in its individual and social aspects has been able to knit together in a comprehensive theory of mind offences which appear to spring from different sources. In the same way as the law embraces a wide variety of offences regarded as criminal by a given community, so too does psychoanalysis embrace the same variety in its theory of mental development, seeing perhaps common dynamic features in the wide range from murder, through sexual offences, and on to Treason. Indeed in primitive communities the distinction between the public and the individual was far from clear and the Tort and the Crime were not distinguishable, as we see in the Law of Talion.

Sociologically, and Dr Glover by no means ignores social determinants in criminal conduct, we are not altogether free from the primitive notion of vengeance, even at a time (shall we say, since Jeremy Bentham) when we are inclined to discount our feelings of vengeance and consider that crime was largely, as Bentham held, contrary to public utility. If indeed we were to follow the great Utilitarian we would come closer to the author of this volume than may be apparent in viewing criminal conduct in the light of psychological motivations which in terms of Freudian doctrine have a distinctly hedonistic flavour.

In taking at first a bird's eye view of this volume covering in the author's working time fully thirty-seven years the reader will be struck by the fact that without sacrificing his classical Freudian position regarding the dynamics of conduct, he has been progressively more and more alive to the work and attitude of sociologists and to the ancillary aid of the clinical psychologists in testing for traits and attitudes. Dr Glover fully realizes the social significance of legal usages and the grounds for the law's delay in accepting those changes which psychology in particular may press.

Dr Glover does full justice to the progressive work done in Britain between 1912 and 1959, particularly the work of the I.S.T.D. which as early as 1930 was working against prejudice in the high places of both Psychiatry and the relevant government departments. The author's coverage is very wide. Sections III, IV, and V cover the field of diagnosis of Pathological Delinquency, Criminal Psychology, and the varieties of sexual offences that lie within the frontiers of criminality as defined by a particular national culture and its code. Part VI is concerned with research by team work and the advances in the understanding of the Criminosis made through the application of psychoanalytic theory and actual practice with offenders; and more important still with analysed persons who frequently disclose some of the larval mechanisms of crime.

Seeing that a large proportion of this book is derived from the author's writings over thirty years of practice and theoretical formulation one might have expected a loosely laid out mosaic, but

taking the volume over-all it is a clear sequential exposition of the evolution of a discipline, and a consistent attitude of a Freudian who is prepared to take much from sociology and general psychiatry. The progression from section to section is logical and internally consistent.

There are areas of study in which the reader may not always be satisfied with the author's argument or with the emphasis he lays on certain issues. For example it is not always clear what distinction he draws between Constitution and Predisposition. It is true that genetic studies have not so far given us much enlightenment, with perhaps the exception of major mental disorders associated with anti-social conduct. That genetic factors must play a part is obvious, and if so they play upon the early situations which create predisposition. It would be best to accept these possibilities and not to ignore them if a correct prognosis and a helpful classification are to emerge. Dr Glover does stress the poor state of our classification. Upon it prognosis and treatment through selection will win the approval of the lawyers who want guidance and not dogmatism which they will use as arguments against scientific progress.

It is difficult to cover critically all the interesting topics which Dr Glover handles with thoroughness and characteristic punch, but certain subjects must claim attention and the outstanding one is the problem of the Criminal Psychopath, well described as the scandal of Psychiatry. Dr Glover pays tribute to Pritchard who was the first to define the moral obliquity of the type, a concept which has close relation with the psychoanalytic theory of guilt and the evolution of the super ego as the regulative principle of conduct. This regulative principle is the kind of cybernetic organ of moral equilibrium which makes character both resilient and rigid by turns.

Its poor development with or without the operation of a sound intellectual instrument is the source of much that enters into the mentality of the asocial and the antisocial type. The author has devoted over fifty pages to this issue, the psychopath. Some workers in the field of delinquency might conclude, and with justice, that when the total field of criminal and antisocial behaviour is surveyed, that the flimsy framed class of psychopaths may prove to be both a clinical and logical paradigm, a pattern for the purpose of scanning as it were the range from normal undertones of asocial behaviour as a potentiality, to the major

psychoses with associated behaviour, criminal but not culpable in the McNaghten sense.

Dr Glover is very sensitive to the incompleteness and inadequacy of existing psychiatric classification; it is still more evident in regard to the forms of delinquency. Psychiatry is still too tied to the classical forms of the major psychoses with the neuroses hanging on as minor nuisances. On the whole it has (psychoanalysis apart) ignored the important realm of character disorders the study of which discloses the possibility of asocial conduct. A theory of mind, he emphasizes is necessary before we can take the subject of psychopathy out of the morass and put it in a spectrum of mental functioning. To pursue the analogy; it may not have a polarity relationship to such a range, but may represent the Fraunhofer lines of impurity in the mental structure due to processes not yet clear to us. It is true that the larger number of such persons do not reach clinical scrutiny and that actuarially we have a poor sample. The eccentrics, the tramps, the clochard, the misfits who fall by the way in certain phases of life only, are parts of the social scene and not of the clinical field. The saints of darker ages than our own sometimes belonged here for part of their lives, before the prevailing religion gave them a new design for holy living.

These types are deserving of our attention for they might, being frontier types, disclose both in surface and in depth the nearness of the psychopaths to many normals in our midst. Nor can we ignore the cultural determinants which make it imperative for a given culture to create its own outlaws. The more the psychopath is examined in the light of untreated so-called normal persons the more we realize that it is a condition which has phases, some fleeting as in adolescents. Most stabilize in a fashion with middle age. It may be a pattern upon a normal ground in others. While Glover accepts the view of Pritchard that the psychopath is the morally oblique he seems to deprecate society's criticism and rejection of him. But as society is in essence a moral order, the morally oblique must remain a foreign body. Society may be an aggregation of mutually dependent persons who cohere through the possibility of love bonds, it is also an order relationship in the interest of that stability which is in perpetual peril from man's inhumanity to man. The author can scarcely expect the public, let alone its legal arm, to adopt an entirely clinical attitude to those

whose conduct strikes at its roots. Yet he too does not expect, just yet, a psychiatric millennium. He adds, 'the psychiatrist cannot altogether dissociate himself from the ethical implications of their diagnostic terms... without being dubbed Public Enemy No. 2'.

Nevertheless, starting from the Freudian concept of the Polymorphous 'pervert' nature of the child, all the adult aberrations of the adult sexuality lie exposed, and the ethics of the developed society lie equally exposed, but not disposed of.

We do not bring summarily to an end the moral dictates of a society of which even its primitive and simpler forms are already organized for conservation. With time and growing tolerance of the causes and consequences of our discontent, we should be prepared, indeed we must be prepared, to sacrifice the excellences which restraints on instinct have created. Dr Glover deals with these issues of society's restraints and penalties imposed for infringements repeatedly in the attempt to justify psychiatry's and mainly psychoanalysts' pleas for meliorism via insight and liberation rather than further restraint. In this regard he has to face the still unsolved problem of responsibility. Society cannot resist, it dare not resist, placing an enormous emphasis upon conscious controlling forces. These are socially aroused attitudes and activities, and in this realm we feel responsibility has been given to man, perhaps in childhood by the love and authority of parents—the licence to grow up only if—, as if to say society has given us rewards for conformity; and thus the individual must in doubtful recognition give back in obedience and in contriteness of heart. The guilt and anxiety generated by this impasse is one of the roots of criminality, i.e. asociality in one way or another. Thus the frontier between crime of normality and of neurosis becomes more and more like the equator, an imaginary line, but like this geophysical line of demarcation it has profound meanings for man who in virtue of his acquired sociality is obliged to produce not only a psychology of morals which understands and treats moral obliquity in criminal forms but a rational metaphysic of morals which is perhaps more than a rationalization. Nevertheless, the scientific objective study of all forms of conduct must stand as a balancing organ between both these weighted attitudes. This attitude if well maintained will do much as Dr Glover argues to being together

the legal defenders of conforming behaviour and the psychological examiners of the roots from which conformity and non-conformity seem to have their origin.

Dr Glover's book has such a wide coverage, leaving so few aspects unexplored that it will, despite its guarded optimism on matters of treatment, remain a guiding light to all students of criminal behaviour; sociologists and lawyers, as well as psychiatrists.

EMANUEL MILLER

Handbook of Abnormal Psychology. An Experimental Approach. Edited by H. J. EYSENCK. (Pp. 816. £6.) London: Pitman Publ. Co. 1960.

This book touches upon many problems of psychology and psychiatry. No single reviewer can offer an expert opinion on more than a few aspects of abnormal psychology as presented in this volume which consists largely of surveys of work published elsewhere. This reviewer proposes to discuss mainly those parts which are of direct interest to the clinical psychiatrist. The book has altogether nineteen contributors, all but three of whom are or were psychologists working in close association with the editor. Only two of the articles have been written by psychiatrists, i.e. the one on heredity (J. Shields & E. Slater) and the one on constitutional factors in relation to abnormal behaviour (L. Rees). Both those articles are highly informative. The basis of the book is antiholistic, antipsychodynamic and antipsychiatric in general. Much of the criticism of what doctors are doing and thinking is uninformed and unfair. The editor sets the tone in the first chapter. He promises to show that schizophrenia, hysteria, anxiety states and the like are not medical disease entities. He declares that he and his associates having rejected the psychiatric framework outright, will not be 'bound and constrained by diagnostic schemes of dubious validity and known unreliability'. He fails to inform his readers that two generations of psychiatrists in this country and America have rejected the concept of disease entities and that psychiatrists everywhere are only too well aware of the inadequacy of their diagnostic schemes. He proposes to divide psychiatry into the 'medical part' dealing with the effects of physical disease, and the 'behavioural part', i.e. disorders of behaviour. The latter com-

prises the neuroses and the so-called functional psychoses. The two parts have, in his opinion, no underlying connexion and have become associated with each other only by historical accident. It was through such accidents that G.P.I. and similar diseases have been classed with the psychiatric disorders. This is an astonishing observation made by a psychologist working in a psychiatric institute. Medical disorders, unlike the behavioural disorders, have a single 'cause', with constitutional and environmental factors being 'merely contributory'. The editor seems quite out of touch with present-day medical thinking and his knowledge of psychiatric history is faulty. Having solemnly abjured the psychiatric framework, he and his associates constantly work with the very concepts they condemn. In fact they treat them as if they had a high degree of reliability. To the psychiatrist it means very little that groups of hysterics, dysthymics, psychopaths, schizophrenics, etc., were submitted to batteries of tests, unless he knows what concepts of hysteria, psychopathy etc. were employed. They vary considerably even among members of one and the same psychiatric institute. Eysenck and his associates, in spite of their frequent declarations of independence from psychiatry, seem unable to dissociate themselves from psychiatric criteria of diagnosis and classification. This may be inevitable, but why all those protestations of complete independence? The psychiatrist given in this book is in fact interested in the same problems as the psychologist but, being a doctor, in a few others also.

The book falls into three parts, the first entitled 'description and measurement of abnormal behaviour', the second 'causes and determinants of abnormal behaviour', the third 'experimental study and modification of abnormal behaviour'. One of the chapters deals with psychotherapy. Eysenck's criticism of psychotherapy has become a set piece which does not improve with repetition. He is a glutton for figures and swallows them indiscriminately. Comparability does not worry him greatly. It is easy to demonstrate from the literature that the recovery rate is the lower the more time the therapist gives to the patient and to conclude that intensive psychotherapy, and especially psychoanalysis, is harmful. This discovery is in keeping with Bleuler's observation that the more thoroughly the psychiatrist examines his schizophrenic patients, the smaller will be his

recovery rate. Similar observations have been made in all fields of medicine. What could be more logical than to assume that the thoroughness of the treatment, or of the investigations, is to blame? Eysenck fails to warn his readers against such pitfalls and he minimizes the difficulties of an evaluation of the value of psychotherapy. He is no longer an uninvolved scientific outsider in matters of psychological treatment. He advocates 'behaviour therapy' of the neuroses, which consists in deconditioning of learned unadaptive behaviour. He has a vision of the psychiatrist of today being replaced by a practitioner of applied physiology, who is to look after the 'medical part' and by the behaviour therapist, i.e. an experimental psychologist who is to deal with the 'behavioural part' of psychiatry. The latter section consists of symptoms only. In this science fiction there is no such thing as 'the patient'. There are only faulty organs and faulty habits, and they are being taken care of by the reconditioners and are deconditioners respectively.

E. STENGEL

Inner Conflict and Defense. By DANIEL R. MILLER and GUY E. SWANSON. (Pp. 452. £6.95.) New York: Henry Holt. 1960.

The reader of this important book, which undoubtedly has broken new ground in the study of the determinants of socialization, is faced with a proliferation of concepts and variables. This almost obscures the truly bold, imaginative and provocative thinking which is of great relevance to any workers concerned with the interaction between social and psychological processes as they bear on individual development. The major purpose of the work is to provide a theoretical framework for the understanding of individual conflict, and to indicate how the mode of resolution, the area, intensity and type of conflict is related to social class and methods of child rearing. One hundred and sixteen tables are given which record the results of the many, often ingenious, experiments carried out in order to test the hypotheses.

The authors reasoned that certain parental child rearing practices that differ in terms of social class might reinforce particular reactions to conflict. Their basic problem was the prediction of substitute expressions of needs whose direct expressions are in conflict with other needs or with

moral norms. A need is defined as a system of action tendencies all of which implement the same end state. All the action tendencies of a need have an order of preference with respect to a goal state. The resolution of conflict involves the substituting of certain action tendencies for others. Moral standards affect the hierarchy of preferred tendencies to act and defences help to distort the awareness of the connexion with forbidden objects, acts, affects and agents. Finally, expressive style, the *manner* by which a person performs adaptive acts, also affects the mode of resolution of conflict by limiting the range and type of substituted responses. Thus in analysing the origin of different acts of substitution three components of conflict emerge: (a) the nature of relevant moral standards; (b) the mechanisms of defence; (c) expressive style.

Fundamental to this framework is the assumption that these three components are learned and hypotheses are offered relating to the conditions under which particular reaction patterns are learned. It would seem that nothing of developmental significance is not included in the implications of these 'components'. In other words, mode of resolution of conflict encapsulates the affects of socialization. If this is the case then Miller & Swanson are offering a theory of social learning. It is precisely at this level that the book fails but it is an important failure and consequently much is to be learned from it.

Social class differences in child rearing were systematically related to the results of experiments aimed at measuring the behavioural expressions of the three components of conflict. The authors consider, and this is a contribution to social psychological thinking, that cutting across gross differences in social stratification are different modes of social integration. These modes are conceptualized as *entrepreneurial* and *bureaucratic*. Although many faults can be found with the distinction—*bureaucratic* covers too wide a range of offices, functions and responsibilities in the definition—the concepts place the work in a historical perspective and allow connexions to be made with general structural changes that are occurring in the society. Child rearing practices then are correlated not only with social class but with similarities in occupational role across class.

Defence mechanisms were grouped in two families. The first referred to mechanisms such as

denial which are primitive and have in common the obliteration of objective events and the substitution for them of more tolerable phantasies. Their use results in gross distortions and leads to social difficulties. The second family refers to mechanisms which result in a *displacement* or shift within one or more dimensions of a need (agent, affect, act, object). Unlike family one these mechanisms require very complex skills and each of the defences is applicable only to certain kinds of conflict and results in minimal distortion of actual events. The difficulty of maintaining this classification is epitomized in the discussion of repression. It was in terms of these two families that predictions relating to the mode of resolution of conflict were made and correlated with both social class and to general and particular elements in child rearing practice.

The third component circumscribing the range and type of substitutes involved in response to conflict was expressive style. Five styles were investigated, passivity, degree of emotional dilution, degree of remoteness of substituted acts overlapping the directness of aggression and motoric and conceptual orientation.

Thus the implications of these three components affecting substitution in situations of conflict yield four dimensions of a need, five expressive styles, two families of defences and their elements, moral standards varying according to the range of proscribed acts and felt severity; whilst the social categories which control the components are vertical concepts such as class modified by two types of integration—*entrepreneurial* and *bureaucratic*. The child rearing practices which were considered to have a possible bearing on nuclear learning were toilet training, weaning, discipline (three types), maternal control, requests for obedience and frequency and type of reward. As Rilke wrote: 'Who'll show a child just as it is? Who'll place it within its constellation with the measure of distance in its hand'.

To add to the complication three samples were used, two of adolescent boys and one drawn from male undergraduates. Both adolescent samples were equated on a large number of measures and control of the relevant variables affected selection of members. In fact, as the authors point out, the control was so severe that it is possible that the two samples are not representative of their parent populations. This rigour has probably raised the level of the working-class samples. A methodo-

logical discussion of the problems this massive study raised is presented in the postscript. Different subjects are used for many of the tests and the number of subjects varies from 116 to 38 in any one result. The techniques relied on story completion tests except for the studies on sexual identity and expressive style. A separate review would be necessary to deal with the problems raised by the research techniques and the experiments carried out.

It is also clear that it is not possible to do more than select from the 116 tables of results. The task of integrating the over-all results into some type of pattern or at least summary statements was, it seems, even too much for the authors. When one thinks of the large number of variables and their possible interaction this is quite understandable. The lack of a theory of social learning, a basic necessity for this kind of approach, is responsible for the large number of alternative interpretations given to any one result and this undermines confidence in the necessity of the imputed relationships. Part of the dilemma in interpretation stems from problems in Freudian theory, part from the methods used and too great an emphasis on the role of affective elements in learning. The transformation of social structure into psychological reality is often naïve. Instead of a theory of such transformation a descriptive analysis is offered.

Significant relationships are reported between social class and type of discipline, obedience requests, maternal control, frequency and type of reward, weaning and toilet training; between social class and preference for defence and various interrelationships between child rearing practices, defence mechanisms and expressive style. The presentation of the data could have been much better.

Of considerable interest is the effect of verbal behaviour on the difference found between the two social classes. The authors stated that verbal intelligence interacted with some of the variables in an unanticipated fashion. For example, denial is related to low verbal intelligence. A study of the results relating to social class and broken down into low and high intelligence seems to indicate that even for low intelligence the use of this mechanism is found more frequently among the working-class. Verbal I.Q. was associated with types of request for obedience and type of discipline. It also has a bearing on expressive

style. Thus it affects two of the principal components used to predict the resolution of conflict. The authors prefer to view denial as primary; low intelligence results from the use of this mechanism. Clinically speaking, this may be the case, but none of the samples was under psychiatric care so one can assume that the use of the defence did not create significant pathology. It may be that the social form of a relationship acts selectively on the linguistic process (verbal and non-verbal elements) and this in its turn initiates and reinforces preferences for particular sets of response. In other words the *consequences* of the form of the social relationship (social structure) may be transmitted and sustained by the linguistic process which *itself* became a determinant of the mode of self-regulation achieved by an individual. From this point of view verbal I.Q. may be seen as, in part, a result of the way behaviour becomes subordinate to verbally elaborated meaning. The latter raises the question of the nature of class-determined linguistic forms which are both the expression and regulator of the social relationship.

There can be little doubt that 'Inner conflict and Defense' is a contribution to the literature on social learning. Its shortcomings are a measure of the magnitude of the problem. BASIL BERNSTEIN

The Secret of Dreams. By PEDRO MESEGUER, (Pp. 232. 30s.) London: Burns and Oates. 1960.

One must hand it to the Jesuits. Father Mesequer, in this short terse book reviews the history of views on dreams (e.g. Aristotle, Cicero, Augustine); modern physiological and psychological fact and theory (covering with apparent ease the literature of five modern languages); the evidence for telepathy, and supernatural intervention in dreams; and ends with a careful, subtle, and lucid presentation of his own views on the relationship of dreams and the spiritual life, and the possibilities of their use by a spiritual director.

I would say that this book is indispensable to any Catholic who takes both his Catholicism and dreams seriously.

What value has it to the non-Catholic medical psychologist? What did it teach me? First, and

foremost, a lesson in humility. The scholarship is formidable, and the presentation of the views, even those he most rejects on scientific or spiritual grounds, is always concise and fair. (His presentation of Jung's dream theory is the *pièce de résistance* of this aspect of the book.) His summary of the general empirical characteristics of dreaming is also masterly.

However, any prospective reader for whom contact with the Jesuitical mind is liable to induce something little short of apoplexy, is forewarned that this book is not for him. Father Meseguer is very much a Jesuit, and (this is purely an observation) as far as I could discern, never forgets it.

It follows that while 'the natural, spontaneous "oneiric function" is the subject' of his book, he views this function from his own spiritual position. His larger intention is to 'christianise the whole movement of psychological and psychotherapeutic ideas which has developed from starting points that are, from a Catholic point of view, inadmissible, or at least incomplete' (p. 163).

His position is made clear in his views on sexuality and chastity in relation to dreams. Sexuality has an important part in the dreams of the ordinary run of humanity. At the heights of the fullest expression of Christian continence, however, 'divine love takes the place of human love' (p. 180), yet 'nothing is suppressed, but... everything is outclassed and replaced'. Such sanctification few attain. Even the devout person, whose very marrow is still to be impregnated with divine love, may still succumb to temptation in dreams. 'After dreams that tend to lead us to sin, we should make an explicit rejection on waking, or rather in many cases make our rejection implicit in forgetting them as soon as possible, since it is common knowledge that in matters of sexuality flight is a better form of defence than attack' (p. 167).

Father Meseguer's view that consciousness can 'impregnate' the unconscious to a greater or lesser extent is of considerable interest (rather than the other way round, which is the more usual thought, since Freud). Here, he brings forward important testimony from various ascetics to show that Jung's compensation theory appears to be inapplicable to the psychology of the man who attains the final degree of chastity wherein one does not 'see lubricious phantasies of women even in sleep' (p. 178).

Although such chastity may become second nature, no one ceases to be human, for 'even at

this level the peace of chastity must be armed and watchful: if the vigil lapses concupiscence is always liable to reassert itself' (p. 179) since, 'Sexuality, with its strong organic basis, which makes it follow its own amoral biological course, and its immense affective power in the psyche, is the strongest enemy of spirituality' (p. 178).

Thus, it can hardly be said that he underestimates sexuality. One has to remember this position when one reads, for instance, that 'the aim of spiritual direction is the maturation of the whole human being, external and internal, mental, affective and operative' (p. 212), and those passages where he clearly distinguishes psychotherapy from spiritual direction. Although 'generally speaking', the priest should leave depth interpretations to the psychotherapist, in exceptional cases he may have to 'dabble in psychotherapy', e.g. in the absence of 'a sufficiently capable or sufficiently Christian psychotherapist in the district' (p. 214).

I would not expect him to refer a patient to me.

R. D. LAING

Mental Health and Social Policy 1845-1959.
By KATHLEEN JONES. (Pp. 237. 28s.) London: Routledge and Kegan Paul. 1960.

Dr Kathleen Jones, whose admirable history of the care of the insane between 1744-1845 reviewed a powerful and significant shift of social attitude, here brings the story forward to our own time. She is not to be blamed if the present work is less dramatic than its predecessor, less arresting in its account of the struggle between the powers of darkness and the champions of light. In the present volume legal enactments hold the stage along with committee reports and accounts of the growth of institutions and benevolent societies. Dr Jones has taken as the alpha and omega of her narrative Shaftesbury's Lunacy Act and the Mental Health Act of our own day. While concentrating on central issues, she has deliberately left out of consideration some specialized developments—in child psychiatry, psychoanalysis, and forensic matters: even so, her canvas gets too large, as she approaches the contemporary scene; consequently such topics as the role of Observation Wards, the training of psychiatrists, and the influence of developments in other countries are not given the detailed attention their importance

would warrant in a full survey. This however does not detract from the value of Dr Jones's extensive and well documented study; it provides a much needed account of the stages by which we have advanced to our present social view of mental disorder.

AUBREY LEWIS

An Introduction to Social Psychiatry. By ALEXANDER H. LEIGHTON. (Pp. x and 110. 38s.) Springfield: Charles C. Thomas 1960.

Prof. Leighton's Salmon Lectures are well named and I do not know a better work of introduction to social psychiatry. Dealing with patients in numbers; attention to sociocultural processes; a sense of primary responsibility to a group; carrying the fruits of clinical knowledge into the social system; conducting the results from other behavioural sciences into clinical psychiatry: these, he suggests, are five characteristics constituting a syndrome, a preponderance of which are to be found in any activity to be considered social psychiatry. Wisely sidestepping the obsessional shackles of a *priori* definition, he points out instead the empiric data and the existence of a social psychiatric field, and proceeds to describe the elements in this field and the principles underlying these.

One emergent for psychiatrists is that whatever branch of social psychiatry is practised a particular viewpoint is implied, with its own ethics and responsibilities, distinct from individual psychiatry, though consonant with it. This viewpoint is derived not only from psychiatry but from other relevant social sciences. (It is noteworthy that the author is a professor of Psychiatry, Sociology and Anthropology at Cornell.)

This modest, disciplined account of the actions of social psychiatry and the principles and pitfalls of basic and applied research emphasizes psychiatry as a behavioural science capable of making a unique contribution because of its special strength: knowledge of psychopathology; knowledge of human motivation; and experience in dealing with human personality conceived as a whole, as a self-integrating unit. The book finishes with an excellent annotated bibliography, to which this book is a useful introduction.

T. F. MAIN

Understanding Interrelations in Nursing. By LESTER D. CROW and ALICE CROW. (Pp. 449. 45s. 6d.) London: Macmillan. 1961.

In the preface of this book the authors say, 'It is the responsibility of the nurse to (1) discover her own strengths and weaknesses, (2) recognize the sociological forces that impel others to behave as they do, and (3) develop wholesome and constructive relationships between herself, as a practising nurse, and those with whom she works: patients, the family and friends of the patient, supervisors, and nursing colleagues.'

From this and the title one is led to expect an exposition, perhaps in some depth, of the many relationships with which the nurse is concerned, and how these affect and are affected by the relationships of her psychic life. Instead the nurse reader is constantly cajoled and admonished, 'nurses must learn to do all things well, both pleasant and unpleasant'. The authors seem to have a particular picture of an ideal nurse and to believe that this can be achieved in a certain way ... 'personality can be changed for the better if the individual is willing to persevere', and she is invited to—'take stock of herself to determine which behaviour patterns should be eliminated'.

There is little attempt at understanding the complexity of interpersonal relationships in depth, so that one is left with an increasing sense of frustration and disappointment as the pages are turned. This is not just because the language is different from that normally met with in training schools in this country.

The method of presenting information is so didactic that the nurse will inevitably come to think that this is just something else to be 'learned'. To make matters worse much more is known and scientifically validated than would appear in this book. The description of a child's development of 'social drives' is pathetic. Even those who would not feel themselves well versed in psychological understanding would question a method of nursing children which includes 'the nurse should ask to be excused from nursing a particular child if he shows signs of developing a strong attachment to her.' There is not a word about what this would mean to the nurse or the child, or how such a relationship can be managed.

To this reviewer it does not seem that the nurse will really understand much more about herself or her patients after reading this book. She will

gather there a lot of things in the authors' eyes, that she should or should not do, but there is enough of this kind of teaching already, without further reinforcement.

W. WEDDELL

Handbuch der Neurosenlehre und Psychotherapie. Edited by VIKTOR E. FRANKL, FREIHERR VON GEBSATTEL and J. H. SCHULTZ. (5 vols. Vol. I, DM 104.00. 1960. Vol. II, DM 107.00. 1959.) Urban & Schwarzenberg. 1959.

This is a monumental work, the like of which does not exist on this subject in any other language. It is predominantly produced by German and Austrian authors including a few emigrants who have retained closer ties with German thinking.

The work as a whole well reflects the German situation. Valuable ground has been lost almost irretrievably through cultural suppression and isolation; yet, as corollary, a tradition has been kept alive and further developed which in turn has become somewhat submerged in Western thinking. The former is most in evidence concerning psychoanalysis with all its modern developments and deviations. Though this is competently represented and its influence is ever present, an urge to catch up and an impatience to go beyond Freud without having had to absorb his work are unmistakable. What results from this is interesting for us here, but the other part—the endogenous German contribution—is of the greatest positive value.

The first volume contains a general theory of the neuroses and of psychotherapy. Historical and social foundations are followed by special reports from all European countries, the Soviet Union, North and South America, East Asia (China). The very competent report on Great Britain by Stengel is perhaps too modest in stating this country's contributions, particularly when compared with the emphasis given to the United States; however, this fact corresponds to the attitude held by German colleagues regarding current contributions from Britain and America respectively which struck the present reviewer when he recently attended the Lindau Psychotherapy week by invitation. The report on the U.S.A., by Hofstatter, is very enlightening in its

sociological analysis of the American scene, and is of great interest.

Neurosis is differentiated from the norm, from psychopathy and the psychoses, and is presented in the framework of medicine and psychology. J. H. Schultz develops a holistic, biological, and Wiesenhütter a comprehensive sociological view. The rest of the first volume is devoted to method, the psychotherapeutic situation, testing, statistics, problems of training and the law. Siebenthal writes on dream interpretation as a central method of psychotherapy and Kemper gives a practical outline of its basic principles.

The second volume deals with the special theory of the neuroses. An introductory section treats hereditary and constitutional aspects, a concluding one the social neuroses, e.g. in connexion with accidents and industry. The heart of the volume considers neuroses in three sections. The first presents classical syndromes, e.g. phobic, obsessional (called anankastic), and hysterical (but also depressive, schizoid, paranoid as well as addictions and perversions) as 'Fehlhaltungen' (faulty attitudes). Freiherr von Gebattel's existentialistic, anthropological approach gives this section its characteristic note. In a second section different age groups are considered: childhood, young years, and the second half of life. The last, by Kehrner, is in agreeably sober and clear language and gives much factual information. This is mentioned as a contrast to a number of articles throughout these volumes which often have a characteristic literary flavour and phraseology, and sometimes overelaborate historical and philosophical foundations. This feature is noticeable particularly because it recurs in a good proportion of the contributions and is the only major criticism the present reviewer would make.

A third section, perhaps the most interesting one, bears the subtitle 'Organismische Lebensvollzüge' which is difficult to translate; it means something like 'organismic modes of living'. This deals with a medley of topics, e.g. disturbances of sex life, speech, sleep, but also conscience; on the other hand, circulation, respiration, and nutrition are each the subject of a separate study. These are of special value, combining as they do comprehensive surveys with the personal, original views and investigations of the respective workers. The one on nutrition, by Glatzel, is particularly good.

S. H. FOULKES

The Anatomy of Judgment. By M. L. JOHNSON ABERCROMBIE. (Pp. 156. 25s.) London: Hutchinson. 1960.

This book is the result of ten years of research during which a long series of experiments in perception and the expression of judgments was conducted with a class of senior students. Among the valuable results was the disclosure of unexpected barriers to learning imposed by emotional difficulties, and the application of a technique to overcome such difficulties. This is fully described.

A method of teaching by holding group discussions was devised to help students to observe, describe, classify and evaluate experimental evidence with well-founded confidence. The investigation of mental processes includes the application of principles derived from recent studies, such as those of Ames, with interesting results. The book itself provides an excellent introduction to the study of perception.

Child Guidance Centres. By D. BUCKLE and S. LEBOVICI. (Pp. 133. 20s. \$4.00, Sw. Fr. 12.) Geneva: World Health Organization. 1960.

The authors, a psychologist and a psychiatrist, have sought to cover as wide a range as possible by drawing on the papers presented and discussions held at a seminar which took place in 1956 in Lausanne under the auspices of W.H.O. This monograph gives detailed information on the location, equipment and work of many different types of child guidance centre and discusses the qualifications which should be possessed by members of the child guidance team. A description is also given of the special techniques to be employed in case-finding, history taking, diagnosis and treatment of behavioural troubles in children.

An Introduction to Psychoanalytic Research. By KENNETH CLARK COLBY. (Pp. 117. \$3.00.) New York: Basic Books. 1960.

Dr Colby proposes methods for adapting, within the accepted psychoanalytic framework, techniques of scientific observation, experimentation and verification. He regards psychoanalysis as a branch of science, proposing a system of theory and observations about human behaviour.

Unsolved problems in psychoanalysis will require the application of scientific methods appropriate to psychoanalytic data by those trained in psychoanalytic observation. This book aims at aiding the investigator in his first searchings in this difficult field.

Hypnosis and Related States. By MERTON M. GILL and MARGARET BRENNAN. (Pp. 405. \$7.50.) New York: International Universities Press. 1959.

This book is a psychoanalytic study of regressive phenomena. The authors apply psychoanalytic ego psychology to the interpretation of data gained in an extensive research project on hypnosis. They first re-examine their basic frame of reference, clarify some of its assumptions and thereby make a contribution not only to the understanding of the variety of hypnotic phenomena but also to the nature of regression.

A great many areas are extensively covered and this work makes a substantial contribution to the literature on hypnosis.

The First Five Minutes. By ROBERT E. PITTINGER, CHARLES F. HOCKETT and JOHN J. DANEHY. (Pp. 264. \$6.50.) New York: Paul Martineau. 1960.

This 'sample of microscopic interview analysis' draws upon the technique of psychiatry and anthropological linguistics. The authors present an examination of a segment of an interview recorded in sound. In employing new tools of observation they show that it is possible to have a sharpened accuracy of perception and to enlarge the volume of phenomena brought to awareness. The authors report on their methods of research and present principles of behaviour uncovered or reinforced by the use of this new tool. At the close they discuss some of its immediate uses in practice.

Classification of Mental Disorders. By E. STENGEL. (Pp. 601-633. 3s. 6d., 60 cents, Sw. Fr. 2.) Geneva: World Health Organization. 1960.

Psychiatrists disagree about the concepts upon which a classification of mental disorders should

be based; hence the many classifications, and the frequent description of the same or similar conditions under a confusing variety of names. The effect of this diversity of classification has been to defeat attempts at comparing psychiatric observations and the results of treatment in different countries, or even in different centres of the same country.

In recent years the epidemiological approach to mental disorders has been more and more employed. To be used successfully and on a wide scale such an approach requires a common basic terminology and classification. As a first step towards this, the author of this paper examines critically the classifications in current use. He shows that some of the difficulties created by present-day lack of knowledge are surmountable by the use of 'operational definitions', and he outlines the basic principles on which, he believes, a generally acceptable international classification could be constructed.

The paper reproduces thirty-eight classifications in detail, and contains a useful reference list.

Uprooting and Resettlement. World Federation for Mental Health. (Pp. 149.) London and New York: World Federation for Mental Health. 1960.

This volume contains papers presented at the Eleventh Annual Meeting of the World Federation for Mental Health in Vienna in August, 1958. The chapters include 'Man's Responsibility in the World' by Dr Brock Chisholm, 'Uprooting and Resettlement as a Sociological Problem' by Dr Maria Pfister-Ammende, 'Common Psychological Factors in Refugee Problems throughout the World' by Mr Elfan Rees, 'Identity and Uprootedness in our Time' by Prof. Erik H. Erikson, and 'Observations on the Mental Health of Refugees' by Dr H. Strotzka. A panel session has considered the place of mental health in the planning of immigration programmes and further chapters deal with voluntary migrants, psychological problems of the voluntary migrant to Australia, resettlement in Canada and home and identity. Dr Soddy reviews the discussion groups in some detail.

Action for Mental Health. The Final Report of the Joint Commission on Mental Illness and Health (Pp. 338. \$6.75.) New York: Basic Books. 1960.

This is the final report of the Joint Commission on Mental Illness and Health, empowered by the United States Congress to conduct the first study of the state of the nation's mental health, and to make recommendations for strengthening it.

Among a number of recommendations calling for increased services is one that the present system of State mental hospitals should be abandoned and replaced by community clinics for out-patient treatment, psychiatric units in general hospitals for short-term in-patient treatment, 'open communities' for those who are acutely mentally ill but who can be rehabilitated, and chronic disease centres for long-term illnesses of all kinds.

Residential Treatment for the Disturbed Child. By HERSCHEL ALT. (Pp. 437. \$7.50.) New York: International Universities Press. 1961.

This book is aimed at providing information for professional workers as well as for members of groups sponsoring residential treatment facilities. Among the topics discussed is the articulation of residential treatment and the underlying theoretical concepts in the fields of psychiatry, psychology, education and social work. The development of programmes, social service, psychotherapy, child care and education are considered.

Dr Alt also discusses the role of clinical staff and auxiliary workers in creating the social milieu to provide a healthy living experience for the child, and goes on to consider the clarification of treatment methods for particular types of disturbed children. Finally, the research and training functions of residential treatment centres are discussed.

The Informed Heart. By BRUNO BETTELHEIM. (Pp. 309. 35s.) London: Thames and Hudson. 1961.

From his own experience in Dachau and Buchenwald and from his knowledge as a practising psychoanalyst both before and after the rise and fall of the Nazi regime, Bruno Bettelheim

has described in detail the breakdown of human behaviour under extreme conditions. He shows how personality can disintegrate under a repressive regime out of pure anxiety, so that people will believe what they would know to be false if their anxiety permitted them to know it. This book also contains sections on the psychological issues involved in such wide-ranging subjects as children's television and automation.

The Central Nervous System and Behaviour.

Transactions of the Third Conference. Edited by MARY A. B. BRAZIER. (Pp. 475. \$7.50.) New York: Josiah Macy, Jr., Foundation. 1960.

This report of one of the multiprofessional conferences sponsored by the Josiah Macy, Jr., Foundation contains chapters on the evolution of man's brain, the biochemical maturation of the central nervous system, neuronal models and the orientating reflex, concepts of drive, affectional behaviour in the infant monkey, verbal regulation of behaviour and signalling systems in the development of cognitive functions. There is also a list of articles translated from the Russian medical literature.

The Prediction of Overt Behaviour through the Use of Projective Techniques.

By ARTHUR C. CARR and OTHERS. (Pp. 177. 54s.) Springfield: Charles C. Thomas; London: Blackwell. 1960.

The purpose of this volume is to assess the extent of present knowledge of the major projective techniques (the Rorschach Test, the Thematic Apperception Test, the Bender-Gestalt Test and the Sentence Completion Test). It represents the proceedings of a symposium presented at the Annual Convention of the American Psychological Association.

Nerves, Brain and Man. By JOHN GRAYSON. (Pp. 243. 25s.) London: Phoenix House. 1961.

This work is concerned with the machinery of the nervous system, combining the approach of the anatomist with that of the physiologist and the electronic physicist.

Personality. By ROBERT W. LUNDIN. (Pp. 450. 40s.) New York and London: The Macmillan Company. 1961.

The author takes the point of view that if personality is to remain a legitimate part of scientific psychology it must abandon untestable hypotheses and fictional concepts and become amenable to empirical investigation. This book represents an elaboration by the author of this view.

From Adolescent to Adult. By PERCIVAL M. SYMONDS with ARTHUR R. JENSEN. (Pp. 413. 70s.) Columbia: University Press; London: Oxford University Press. 1961.

This study follows up the late Prof. Symonds' book *Adolescent Fantasy*. The present study deals with twenty-eight persons from the first study, all of whom could be contacted thirteen years later. In this work the correspondence between adolescent fantasy and the subject's adult experience and personality is analysed.

Existentialism and Psychiatry. By RUDOLF ALLERS. (Pp. 103. 44s.) Springfield: Charles C. Thomas; Oxford: Blackwell. 1961.

The four lectures included here relate to psychiatry and the intellectual climate at the turn of the century, to existentialism and the existential approach to psychiatry. Finally, the scope and limitations of the existential approach are examined.

Self-Organizing Systems. Edited by MARSHALL C. YOVITS and SCOTT CAMERON. (Pp. 322. 60s.) Oxford: Pergamon Press. 1960.

This volume contains proceedings of a conference co-sponsored by the Information Systems Branch of the United States Office of Naval Research and the Armour Research Foundation, and includes both the prepared papers and the associated discussion. The fourteen formal papers refer to perception of the environment, effects of environmental feedback, learning in finite automata and structure of self-organizing systems.

Physical Disability—a Psychological Approach
By BEATRICE A. WRIGHT. (Pp. 408. 42s.)
New York: Harper & Brothers; London:
Hamish Hamilton. 1960.

The author uses as a basis for discussion not separate disability categories (such as blindness or crippling) but rather situations common to all disability groups of all ages. Concrete examples are cited throughout the discussion. Both factors within the person and factors attributable to the environment are considered in terms of how they aid or hinder psychological adjustment.

The Unconscious Before Freud. By LANCELOT LAW WHYTE. (Pp. 219. \$4.50.) New York: Basic Books. 1960.

Mr Whyte attempts to trace the concept of an unconscious mind back to the seventeenth century and to show that it was a commonplace of advanced European thinking a generation before Freud began his work.

A Minority. By GORDON WESTWOOD. (Pp. 216. 30s.) London: Longmans, Green. 1960.

Over a period of two years Mr Westwood met and talked to more than one hundred homosexuals and has obtained factual information on their family background, social behaviour and sexual activities. The material obtained by Mr Westwood is summarized in this book with frequent use of verbatim quotations.

Homosexuality. By D. J. WEST. (Pp. 220. 3s. 6d.) London: Penguin Books. 1960.

The author summarizes, in this revised Pelican edition, the facts about homosexual behaviour in primitive communities, in historical times and in animals. He leads up to a more comprehensive description of social, legal and moral problems.

An Introduction to the Psychoanalytic Theory of Motivation. By WALTER TOMAN. (Pp. 353. 60s.) London and New York: Pergamon Press. 1960.

The author attempts to bring the reader into contact with the basic concepts and 'the grammar'

of psychoanalytic theory. Special emphasis is placed on the system properties of the theory, on clarification and further articulation. The author applies his theory to everyday life, to the development of personality from childhood through adolescence to adulthood, and also to psychopathology.

Surgery as a Human Experience. By JAMES L. TITCHENER and MAURICE LEVINE. (Pp. 285. 48s.) London: Oxford University Press. 1960.

The authors integrate concept and treatment methods from both the surgical and psychiatric disciplines in an attempt to evaluate and understand the psychology of being sick—especially being sick with an illness that requires surgery.

The text is a close study of the mutual influences of the anatomical alterations, physiological changes, and psychological conflicts that are reactions to the surgical experience.

Stress and Psychiatric Disorder. Edited by J. M. TANNER. (Pp. 151. 21s.) Oxford: Blackwell. 1960.

This book contains the twelve papers given at a conference organized by the Mental Health Research Fund. A great number of distinguished scientists and clinicians took part. The report itself contains chapters on the disorganization of behaviour in man, and disorganization of behaviour in animals, physiological responses to stressors and the prevention and treatment of psychiatric reactions to stress.

Psychotherapists in Action. By HANS H. STRUPP. (Pp. 388. \$8.75.) New York and London: Grune and Stratton, Inc. 1960.

In this work the author describes the actual data upon which his quantitative analyses of the operations of the psychotherapist are based. He discusses the research issues central to these investigations.

Parent Education. An International Survey. By H. H. STERN. (Pp. 163. 6s.) Hull: University of Hull; Hamburg: UNESCO Institute for Education. 1960.

This survey, prepared for UNESCO, states the case for parent education and reveals world developments in parent education. Four countries (The United States, France, Germany and the United Kingdom) are reviewed in detail and a final section deals with a number of unsolved problems in this field.

Man's Presumptuous Brain. By A. T. W. SIMEONS. (Pp. 281. 25s.) London: Longmans, Green. 1960.

In this controversial book the author puts forward a new theory about the relationship between brain and body and its role in the causation of psychosomatic disorders. The author attempts to bring bodily and psychic interpretations together on common evolutionary ground.

Current Psychological Issues. Edited by G. S. and J. P. SEWARD. (Pp. 360. 42s.) London: Methuen. 1960.

This book celebrates Prof. Woodworth's arrival at his ninetieth year and consists of studies contributed by his friends and colleagues. The three main sections, apart from a study of Woodworth himself by Georgene H. Seward, refers to the S-O-R Process, the physiological substrate and social norms and the individual.

A History of Psychiatry. By JEROME M. SCHNECK. (Pp. 196. 44s.) Springfield: Charles C. Thomas; Oxford: Blackwell. 1960.

This compact volume aims at enhancing historical perspectives for the undergraduate medical student and to round out the post-graduate student's view of psychiatry.

Group Processes. Transactions of the Fifth Conference. Edited by BERTRAM SCHAFFNER. (Pp. 196. \$4.50.) New York: Josiah Macy, Jr., Foundation. 1960.

These transactions of the Fifth Conference contain sections on experimental aspects of paediatrics, the analysis of behaviour in terms of control systems, and the cult as a condensed social process.

Jordi. By THEODORE ISAAC RUBIN (Pp. 73. 10s. (20s. cloth).) London and New York: The Macmillan Company. 1960.

In this small book Dr Rubin attempts to show the workings of the mind of a schizophrenic child by telling the story of the hypothetical 'Jordi' in a reconstruction of what the child's own world might be.

Portrait of Social Work. By BARBARA N. RODGERS and JULIA DIXON. (Pp. 266. 25s.) London: Oxford University Press. 1960.

This comprehensive examination of our social services includes a detailed survey of social work in relation to local government, central government and voluntary organizations.

An Introduction to Experimental Design. By WILLIAM S. RAY. (Pp. 254. 45s. 6d.) New York and London: The Macmillan Company. 1960.

The author begins with the simplest ideas and principles of experimental design and analysis and then takes up a few central developments, ending with a number of advanced topics and issues.

Learning Theory and Behaviour. By HOBART O. MOWRER. (Pp. 555. 56s.) London & New York: John Wiley and Sons. 1960.

Using a predominantly developmental approach, Dr Mowrer attempts a high-level synthesis of the field of learning theory and behaviour. Research and conjecture are examined in a broadly historical context and the author makes use of many new experimental findings not available to earlier

system makers. He proposes a new system with greater scope and power than has been previously achieved.

One of Those Children. By ELIZABETH NEAL. (Pp. 198. 18s.) London: George Allen and Unwin Ltd. 1961.

This is the story, by his mother, of the home life and education of a spastic boy, of whom the doctors had declared that he would never walk or talk and that he could not be expected to survive more than two or three years. In fact, he did survive, and this book describes how the mother handled her problem and the child's progress along the path of becoming a happy and partially self supporting member of the community.

Tenderness and Technique: Nursing Values in Transition. By GENEVIEVE ROGGE MEYER. (Pp. 160. \$2.75—Monograph series: 6.) Los Angeles: Institute of Industrial Relations, University of California. 1960.

Dr Meyer gives an account of a research project into the roles and functions of the professional nurse. The organizing theme of this study has been the fluctuating relationship between the two major nursing traditions of *tenderness* and *technique*.

Origins of Alcoholism. By WILLIAM and JOAN MCCORD. (Pp. 193. 35s.) London: Tavistock Publications. 1960.

More than five hundred boys whose early environment, physiological constitution, personality and family structure have been studied in detail (the Cambridge-Somerville Youth Project) have now been studied again in their adult lives. Of these, twenty-nine have become alcoholics. By comparing these men with other members of the group the authors have distinguished a pattern of experiences and traits that set the alcoholic apart as a distinct type before alcoholism itself appears. Stress is laid on early dependency conflict and certain aspects of the mother's role, in conjunction with other variables which produce unusual stress and confusion in the self-image.

A new and admittedly speculative theory based on these findings opens up many questions for further investigation.

The Anatomy of Psychotherapy. By HENRY L. LENNARD and ARNOLD BERNSTEIN. (Pp. 209. 48s.) Columbia: University Press; London: Oxford University Press. 1960.

The authors attempt to demonstrate in detail how the sociological approach can yield insight into problems of psychotherapy. The mutual relevance of ideas and methods drawn from small-group research, role theory, information theory, social system theory, and those drawn from psychoanalytic theory and clinical psychology is discussed.

The authors analyse the communication represented by more than five hundred tape-recorded sessions from eight individual therapists. They are particularly concerned with the therapist-patient relationship.

Learning and Behaviour. By REED LAWSON. (Pp. 447. 47s.) New York and London: The Macmillan Company. 1960.

This introduction to learning theory deals with simple habit-formation, the interaction of simple habits, factors presumed to complicate the simple learning model and 'complex' learning cases.

The Freudian Ethic. By RICHARD LAPIERE. (Pp. 299. 25s.) London: George Allen and Unwin. 1960.

The subtitle of this book is 'An analysis of the Subversion of the Western Character'. The author attempts to show that the decline of the Protestant ethic in the last few decades has been associated with the emergence of a new ideal for man which takes its cue from Freudian psychology. The author believes that the Freudian ethic may result in a dangerously large reduction in initiative.

Tropical Childhood. By DAVID LANDY. (Pp. 291. 48s.) North Carolina: University Press; London: Oxford University Press. 1960.

A study of cultural transmission and learning in a rural Puerto Rican village.

The Psychogenesis of Mental Disease. By C. G. JUNG. Collected Works, Vol. 3. (Pp. 312. 32s.) London: Routledge and Kegan Paul. 1960.

Prof. Jung's famous Monograph 'On the Psychology of Dementia Praecox' has been made available in this volume in an entirely new translation by R. F. C. Hull. Grouped with it are nine other papers in psychiatry, the earliest being 'The Content of the Psychoses' written in 1908 when Jung was a leading member of the early psychoanalytical movement. The latest are two papers written in 1956 and 1958, which embody his conclusions after many years of experience in the psychotherapy of schizophrenia. These studies reflect the original techniques especially associated with Jung's name.

Volume 3, with bibliography and index, is the tenth to appear in the Collected Edition.

Race Relations and Mental Health. By MARIE JAHODA. (Pp. 48. 2s. 6d.) London: H.M. Stationery Office. 1960.

The chapters in this publication deal with the psychological function of prejudice, psychogenetic origin of prejudice, prejudice and mental health and the inevitability or otherwise of prejudice. A bibliography is included.

The Single Woman. By LAURA HUTTON. (Pp. 132. 12s. 6d.) London: Barrie and Rockliff. 1960.

This is a revised and expanded version of a book which has been well known for some years. It has now been made available for a wider public, and is aimed at helping the unmarried woman whose problems of adjustment may be acute.

Emotion. By JAMES HILLMAN. (Pp. 318. 40s.) London: Routledge & Kegan Paul. 1960.

This is an anthology of theories of emotion, and contains, at the same time, a critical analysis of different ways of thinking about emotion. The concepts of emotion in contemporary American psychology and continental existentialism, in psychiatry, physiology and philosophy, in psychosomatics, psychopharmacology, psychosurgery, parapsychology and in the main psycho-

therapeutic schools, are all reviewed. Finally, the author attempts a synthesis by means of a multi-causal approach.

Creative Variations in the Projective Techniques. By MOLLY HARROWER, PAULINE VORHAUS, MELVIN ROMAN and GERALD BAUMAN. (Pp. 138. 68s.) Springfield: Charles C. Thomas; Oxford: Blackwell. 1960.

The main sections of this book deal with projective counselling as a psychotherapeutic technique, the structured interview technique, and interaction testing (a technique for the psychological evaluation of small groups). There is an introduction by Bruno Klopfer.

Psychological Scaling. Edited by HAROLD GULLIKSEN and SAMUEL MESSICK. (Pp. 211. 40s.) New York and London: John Wiley and Sons (Chapman and Hall). 1960.

This book presents a series of articles by fourteen leading behavioural scientists and research workers, surveying the present state of psychological measurement and also indicating possible future developments in the theory and application of psychological scaling methods.

Americans View their Mental Health. By GERALD GURIN, JOSEPH VEROFF and SHEILA FELD. (Pp. 444. \$7.50.) New York: Basic Books. 1960.

Using the methods of opinion research and insights of social psychology, a team of field investigators of the University of Michigan's Survey Research Center conducted extensive interviews with thousands of Americans selected to represent a cross-section of the country's entire population.

Among the subjects dealt with in the interviews and reported in detail in this volume, are: the degree of satisfaction with the marital relation; contentment or frustration on the job; attitudes towards the rearing of children; the relationship between religious feelings and mental health; the feelings of unmarried men and women about their status; the relationship between educational attainment and self esteem, and the ways in which people attempt to solve their emotional problems.

Behaviour Therapy and the Neuroses. Edited by H. J. EYSENCK. (Pp. 479. 63s.) London and New York: Pergamon Press. 1960.

The series of readings contained in this book illustrate the hypothesis that rational treatment of neurotic disorders can only be developed by drawing upon modern learning theory and treating neuroses as learnt habits. The name 'behaviour therapy' given to this treatment is meant to distinguish it from psychotherapy.

Perspectives in Personality Research. Edited by HENRY DAVID and J. C. BRENGELMANN. (Pp. 370. 50s.) London: Crosby Lockwood and Son, Ltd. 1960.

This second 'Perspectives' volume, prepared under the auspices of the International Union of Scientific Psychology, had its origin at the 15th International Congress in Brussels. The book aims at 'effective penetration of ideas on the international level'. The contributions by psychologists from eleven countries range over such themes as person perception, dynamics of perception, phenomenology of behaviour, longitudinal study of personality, projective techniques and religious psychology.

Early Identification of Emotionally Handicapped Children in School. By ELI M. BOWER. (Pp. 120. 44s.) Springfield: Charles C. Thomas; Oxford: Blackwell. 1960.

The author presents a systematic screening procedure which teachers in schools can employ without a disproportionate amount of time or effort. Five specific kinds of behaviour which can be described as 'emotionally handicapped' behaviour are discussed.

African Homicide and Suicide. Edited by PAUL BOHANNAN. (Pp. 270. 48s.) Princeton: University Press; London: Oxford University Press. 1960.

In the neglected field of comparative criminology, the authors (all of whom have lived in one or more of the seven tribes examined in this study) have studied the official local records for each unnatural death. They relate these acts of violence to the tribal customs and beliefs. Their cases demonstrate the importance of the relation-

ship between killer and victim, the role situation of the suicide, and how the strains in relationships in marital, family and community structures can lead to friction and end in death.

Delinquent and Neurotic Children. By IVY BENNETT. (Pp. 532. 45s.) London: Tavistock Publications. 1960.

The author presents the case histories of one hundred boys and girls, half of whom are neurotic and half delinquent. By comparing a number of aspects of the childrens' lives, the author attempts to show the divergent routes taken in emotional development by delinquent and neurotic children. The author uses not only statistical methods but psychoanalytic concepts as well.

Psychological and Psychiatric Aspects of Speech and Hearing. Edited by DOMINICK A. BARBARA. (Pp. 756. £7. 16s.) Springfield: Charles C. Thomas; Oxford: Blackwell Scientific Publications. 1960.

Twenty-five contributions from well-known authorities in the fields of psychiatry, speech-therapy, speech-teaching, psychology, neurology, and social work compose this comprehensive compendium. Part I deals with psychological and psychiatric aspects of normal and speech and hearing. Part II is concerned with the psychopathology of speech and hearing disorders and Part III with their psychotherapy.

Experimental Psychology. By BURTON G. ANDREAS. (Pp. 595. 56s.) New York and London: John Wiley and Sons Ltd. 1960.

The first part of this book presents the general principles, methods and techniques of experimental psychology. The second describes the application of general methodology and specific techniques to problem areas in behavioural research. The experiments described or referred to are, for the most part, drawn from research journals of the last two decades, and can be modified for use in the undergraduate laboratory. The author's purpose is to permit text material, recent research reports, and laboratory work to be related in such a way as to give the student a feeling of participation in an ongoing scientific enterprise. A chapter on report-writing is included

The Mentally Subnormal. Edited by MARGARET ADAMS. (Pp. 271. 25s.) London: Heinemann. 1960.

This volume deals with the social casework approach to subnormality, and contributions from nine different specialists are included. It aims to outline the different types of social problems and difficulties in adjustment to normal life which arise out of mental subnormality, and to indicate how these may be mitigated or overcome by welfare and training services based on social casework principles.

The Psychology of Crime. By DAVID ABRAHAMSEN. (Pp. 358. 48s.) Columbia University Press; London: Oxford University Press. 1961.

Basing his findings on intensive research and case histories, Dr Abrahamsen considers personality, family tension and psychosomatic disorders, in the derangement of the criminal. He analyses various types of criminals and it is his firm conviction that the solution to the crime problem lies in rehabilitation and prevention rather than in the prevalent practices of actual or threatened retaliation and punishment.

A Young Girl's Diary. Introduced by SIGMUND FREUD. (Pp. 176. 6s.) London: George Allen and Unwin. 1960.

Now available as a paperback.

Nerves and Their Cure. By C. EDWARD BARKER. (Pp. 198. 16s.) London: George Allen and Unwin. 1960.

This small book is written for ordinary sufferers from nervous illness and aims to help them to acquire insight.

The Dynamics of Psychiatric Drug Therapy. Edited by G. J. SARWER-FONER. (Pp. 624. £6. 8s.) Springfield: Charles C. Thomas; Oxford: Blackwell. 1960.

This report of a conference on psychodynamic, psychoanalytic, and sociological aspects of the

neuroleptic drugs in psychiatry contains a report of a free and informal discussion covering various aspects of psychopharmacology. Of special interest is a large section on the effects of the neuroleptic drugs on ego defences and ego structure, and other sections deal with the psychological implications of the physiological effects of these drugs and on the influence of the milieu and the sociological determinants of behaviour. Transference and counter transference problems in relation to drugs as well as their therapeutic aspect are discussed.

The Chemical Basis of Clinical Psychiatry. By A. HOFFER and HUMPHRY OSMOND. (Pp. 277. 68s.) Springfield: Charles C. Thomas; Oxford: Blackwell. 1960.

The authors put forward a number of hypotheses which are relevant to psychiatry. They believe that anxiety may be attributed to hormone imbalance, depression to adrenalin insufficiency, model psychoses and psychedelic experiences to psychotomimetic compounds. Finally, schizophrenia is considered to be related to taraxein formation.

Aspects of the Origin of Life. Edited by M. FLORKIN. (Pp. 199. 30s.) London and New York: Pergamon Press. 1960.

The articles in this volume have been selected from the Symposium on the Origin of Life on the Earth held in Moscow and sponsored by the U.S.S.R. Academy of Sciences.

Chemotherapy in Emotional Disorders. By FREDERIC F. FLACH and PETER F. REGAN III. (Pp. 314. 77s. 6d.) London: McGraw-Hill. 1960.

This work aims at increasing the effectiveness with which clinicians in psychiatry and other fields of medicine employ physiological treatments, in particular the newer psychopharmacological agents in the treatment of patients with various emotional disturbances. It attempts to provide a basis for integration of somatic treatment with psychotherapy.

Clinical Medicine and the Psychotic Patient. Edited by OTTO F. EHRENTHEIL and WALTER E. MARCHAND. (Pp. 383. 86s.) Springfield: Charles C. Thomas; Oxford: Blackwell. 1960.

The authors discuss the problems of diagnosing organic disease in psychotic patients.

The Use of LSD in Psychotherapy. Edited by HAROLD A. ABRAMSON. (Pp. 304. \$5.00.) New York: Josiah Macy, Jr., Foundation. 1960.

In this volume, the five main sections refer to psychoanalytic therapy with LSD, the nature of the psychological response to LSD, symbolisis (psychotherapy by symbolic presentation), the study of communication processes under LSD and the resolution of a father's counter-identification conflict during the oedipal phase of his son.

Neuropharmacology. Transactions of the Fifth Conference. Edited by HAROLD A. ABRAMSON. (Pp. 251. \$6.00.) New York: Josiah Macy, Jr., Foundation. 1960.

This volume contains discussions of amine metabolism and its pharmacological implications, the central action of chlorpromazine and reserpine, the physiological fractionation of the effect of serotonin on evoked potentials, and biochemical sites of action of psychotropic drugs.

Grosse Nervenärzte. (Great Neurologists and Psychiatrists.) 2nd Vol. Edited by KURT KOLLE. (Pp. 251. DM 29.40.) Stuttgart: Georg Thieme Verlag. 1959.

This book presents twenty-two biographical essays on leading scholars and clinicians. The first volume appeared in 1956. Among the subjects of the second volume are Golgi, Nissl, Esquirol, Meynert, Adolf Meyer, Henry Head, Economo, Horsley, Dandy and Dubois. The editor succeeded in securing the co-operation of first-class contributors, such as Sir Geoffrey Jefferson, Critchley, Ackerknecht, Alajouanine, Kleist and O. Vogt. This volume is a welcome addition to the historical literature.

2 Internationales Symposium über die Psychotherapie der Schizophrenie: Zürich 1959. 2nd International Symposium on Psychotherapy of Schizophrenia. (Pp. 300. Sw. Fr. 48.) Basle-New York: S. Karger. 1960.

The symposium was organized by the Institute for Medical Psychotherapy at Zurich. Swiss psychiatrists have for many years cultivated a psychotherapeutic approach on psychoanalytical lines in the treatment of schizophrenia. Speakers of different schools as well as eclectics took part. H. Rosenfeld and Mme. Sechehaye were among the contributors. This report is of importance for all psychiatrists concerned with the psychopathology and treatment of Schizophrenia.

Psychiatrische und Nervenlinik. Krankenvorstellungen. (Clinical Psychiatry and Neurology. Case Presentations.) By KURT KOLLE. (Pp. 252. DM 19.80.) Stuttgart: Georg Thieme Verlag. 1959.

This book has a twofold purpose. It presents neuropsychiatry which, in the author's view, is still not receiving its due recognition in the medical schools, and, secondly, it wants to propagate the great clinical lecture which the author believes to be unsurpassed as a method of presenting clinical problems. There are altogether seventeen lectures consisting of recorded extracts from interviews with patients and followed by brief comments. Up to ten such case records are presented in each lecture, which means that none of them could actually have been held. These case presentations require to be read with the same author's textbook of neuropsychiatry. They show his great skill as a teacher of descriptive neuro-psychiatry with a certain interest in elementary psychodynamics.

Die Entfremdungserlebnisse. (Experiences of Unreality.) By JOACHIM-ERNST MEYER. (Pp. 64. DM 12.60.) Stuttgart: Georg Thieme Verlag. 1959.

The author set himself the task of investigating the factors which precipitated the emergence of

unreality feelings. He is catholic in his approach which is broadly psychodynamic. Acute conflicts frequently acted as precipitating factors. Depersonalization may have a protective function, especially in puberty. He draws an interesting comparison between anorexia nervosa and depersonalization, both of which are in his opinion expressions of withdrawal from reality in the crises of maturation during puberty.

Neurotische Depression. (Neurotic Depression.) By H. VÖLKE. (Pp. 116. DM 16.) Stuttgart: Georg Thieme Verlag. 1959.

The author attempts to delineate a neurotic depressive syndrome from the confusing variety of depressive conditions and to distinguish it from the so-called endogenous and reactive depressions. Unlike the former, which is supposed to be caused by some obscure cerebral dysfunction, neurotic depression is due to psychological factors, especially those arising in middle age. Typical neurotic, particularly hysterical symptoms are usually present. Many cases of this type respond well to psychotherapy.

Klinische Psychopathologie. (Clinical Psychopathology.) 5th Edition. By KURT SCHNEIDER. (Pp. 166. DM 12.80.) Stuttgart: Georg Thieme Verlag. 1959.

This well-known work exerted a considerable influence on German psychiatrists many of whom have in recent years emancipated themselves from Prof. Schneider's dogmatic rigidity. In his approach to mental illness he leaned on K. Jaspers and strongly opposed the psychodynamic orientation. His psychopathology has remained purely descriptive and he has become aware of its narrow limitations in the study of abnormal behaviour.

Der Psychiater. (The Psychiatrist.) By KURT KOLLE. (Pp. 57. DM 5.40.) Stuttgart: Georg Thieme Verlag. 1959.

This is an interesting address about the development of psychiatry and the attitude of the public

to the psychiatrist, who, according to the author, has always been viewed with suspicion and prejudice however eminent and respectable he may have been. This is an interesting observation coming from the present holder of the chair of psychiatry at Munich once occupied by Kraepelin. The author does not attempt an explanation of this attitude to the psychiatrist. His observation is nevertheless of importance because it shows that prejudice against psychiatry is not due to the psychiatrist's orientation, but is obviously rooted in the attitude to mental illness.

Heilpädagogische Psychologie. (Educational Psychology.) 1st Vol. 2nd Edition. By PAUL MOOR. (Pp. 360. DM 32.80.) Berne and Stuttgart: Hans Huber. 1960.

The author set himself the task of examining the usefulness of modern psychology to education. He regards the recognition and mobilization of the potentialities of the individual as the aims of educational psychology. He surveys the contributions of the various schools of psychology as far as they appear relevant to the problems of education. His concepts of developmental psychology are largely derived from Charlotte Bühler. In his theories of personality he follows Klages and other German typologists. In his views on personality and behaviour he learns of Jaspers and other philosopher-psychologists. He has hardly been influenced by psychodynamic or experimental psychology. This book demonstrates the enormous gap between German and Anglo-American psychological schools.

Gruppenpsychologie und Psychodrama. By J. L. MORENO. (Pp. 327. DM 48.) Stuttgart: Georg Thieme Verlag. 1959.

This is an excellent German presentation of the theory and practice of group psychotherapy as founded and propagated by the author, who is one of the most original and provocative among those who grew up in Vienna when Freud was at the height of his creative power. This book can be sure of a good reception among German speaking psychotherapists.

Einführung in die Psychiatrie. (Introduction into Psychiatry.) By KURT KOLLE. (Pp. 92. DM 6.80.) Stuttgart: Georg Thieme Verlag. 1960.

This little book is addressed to both the junior medical student and the educated layman. It presents a historical sketch of psychiatry, its basic concepts, the various schools of thought and methods of treatment lucidly and not too dogmatically. The author advocates the closest possible association of psychiatry with neurology. He wants psychiatric hospitals and departments to be organized and run like medical departments. This orientation is in marked contrast to the efforts made by psychiatrists in this country to get away from the conventional hospital organization.

Selbsterkenntnis und Willensbildung im ärztlichen Raume. (Self-Realization and Motivations in the Medical Sphere.) By W. KRETSCHMER (Pp. 146. DM 19.50.) Stuttgart: Georg Thieme Verlag. 1958.

This book aims at presenting a synthesis of psychotherapy. The author tries to emancipate psychotherapy from a biological orientation as well as from its association with existentialism which has many advocates on the Continent. He favours an anthropological orientation with sociological and educational emphasis. In his view, psychotherapy is fundamentally a cultural endeavour with its roots in religion.



